Punishing Disability: The Lived Experience of Incarcerated Women with Cognitive Disabilities in Australian Prisons

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For my late brother John Martin.

Exceptional paediatrician, exceptional farmer, exceptional human being.

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Abstract

While the needs of women prisoners have received greater acknowledgement within corrective services and academic scholarship, the smaller group of incarcerated women with cognitive disabilities has not generated the same level of awareness. It is reasonable to conclude that in some respects, incarcerated women with cognitive disabilities share similar characteristics with their male counterparts, such as elevated rates of reoffending. However, the difference lies in the notably higher levels of mental illness and rates of abuse, often associated with susceptibility to coercion and poor adaptive skills. This group of women is also exposed to exclusionary processes, both in and out of prison, which may contribute to the cycle of offending.

More broadly, the extant literature draws links between 'social exclusion' and 'incarceration', but little is known about its impact on incarcerated women with cognitive disabilities. This study addresses this gap by providing unique insight into the role of social exclusion in fostering and maintaining the process of 'othering', via stigmatisation that excludes those who are considered 'different'. The study's central argument is that cognitive disability and incarceration are key elements contributing to social exclusion, and that this relationship is mutually reinforcing, in that social exclusion perpetuates cycles of offending. The study has three key objectives: to examine how social exclusion is a factor in pathways to prison, how social exclusion manifests within the prison setting and finally, the capacity of prisons to respond to the needs of cognitively disabled women.

To achieve these objectives, this research privileged the voices of incarcerated women with cognitive disabilities in three Australian states. Between August 2017 and April 2018, semi-structured interviews were conducted in four women's prisons with all women with identifiable cognitive disabilities, as well as the prison practitioners tasked with their cases. The results reveal histories of trauma beginning in childhood, including physical and sexual abuse, foster care, juvenile detention, homelessness, familial suicide and dislocation from communities. The interviews also highlight the role of substance misuse and poor mental health, which often generate challenging behaviours in public spaces. Police interventions, signalling the initial step into the criminal justice system, and limited understanding of court processes contribute to the routine incarceration of this group of women. Cognitive disability is frequently a barrier to bail or parole, with police and court officials adhering to a widely held belief that a lack of capacity to either understand or adhere to bail/parole conditions will result in a breach of conditions. The prison itself contributes to pre-existing trauma via institutional protocols such as strip searches

and isolation. In an environment premised on punishment, surveillance and containment, cognitively disabled women with complex needs are regularly placed in solitary confinement with pharmacological interventions not uncommon.

The research findings are beneficial for Corrective Services and other criminal justice stakeholders, including prison authorities and practitioners, sentencing advisory councils, members of the judiciary, agencies such a Legal Aid, as well as human rights and disability advocates. The findings draw attention to the need for alternatives to incarceration for this vulnerable prison population. Importantly, the study provides a gateway to similar research in other national and international contexts.

Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree. I give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

I acknowledge the support I have received for my research through the provision of an Australian Government Research Training Program Scholarship.

Signed:

Julie-Anne Tŏohey

Date: 21st August 2020

Acknowledgements

My wonderful friend Haylie, fellow PhD candidate and dispenser of wisdom, once said to me, "The PhD is a sole journey, but it is not a lonely one". This perfectly encapsulates the experience of travelling along the PhD road, which is mostly uphill, often filled with potholes, sometimes lacking signposts, but always with the promise of arriving in a place offering satisfaction and a sense of achievement unlike no other. It is not a journey that can be embarked upon without immense support from family, friends and colleagues, and although paying tribute to them here seems such a small gesture in the wake of all they have given me, it is done so with my heartfelt gratitude and the recognition that without them the road would have been far steeper, with more potholes, an absence of signposts and no end in sight.

In terms of supervisors, I won the lottery. No-one could have invested more time, energy, wisdom and handholding than Dr Russell Brewer. Quite simply, this project would never have been completed without him. In fact, this project would never have started without him. I had not planned on doing a PhD - I was content to coast along (on a flat, smooth road with no potholes, a myriad of signposts and a clear destination). However, a 'suggestion' from Russell morphed into 'insistence' by Russell, and so the process began. Russell is a brilliant academic, and out of the jumble of my ideas, long-winded writing and initial structure that was, to say the least, shaky, he brought logic, order and importantly, focus on what he continually referred to as my 'North Star'. Prison research is difficult – anyone who has faced the challenges that roll in like waves from the ocean, would no doubt agree. Having an anchor to keep the boat from drifting is a gift, and one that I will always treasure. Thank you, Russell.

A transfer to the University of Adelaide delivered a second stroke of good fortune: Dr. Dee Michell. Dee is one of the kindest, most thoughtful, and considerate people I have ever met. Dee is also an exceptional scholar, and her guidance in many areas of my PhD, her insightful feedback, the additional food for thought, her great encouragement and her wonderful friendship have given me much to be grateful for. Thank you, Dee.

Professor Mark Halsey's work in prisons provided inspiration to engage in this research. His understanding of the impact of incarceration upon those who live behind prison walls resonated with my personal philosophy, helping to form the theoretical foundations of this dissertation. Thank you, Mark.

My entry into the world of Criminology came on the back of a solitary Summer School unit, completed at the University of Tasmania, under the tutelage of Professor Rob White. There is

no way I could have foreseen the impact of three weeks of compressed study. At that time, I was unaware of Rob's global presence in the field of Criminology – he was, and has always been, too humble to mention it. Over time, I have had the privilege of not only learning from Rob, but also working with him as both a teacher and researcher. To say that his influence has shaped all that has come since would be an understatement. To know him not just as a colleague, but as a dear friend, is quite remarkable. Thank you, Rob.

This research would not have transpired without the support of Corrective Services in Queensland, South Australia, and Tasmania. Their willingness to be involved in my study and facilitate entry to the participating prisons, is something for which I am immensely grateful. This part of the process is often overlooked, as the focus turns to the research participants, organising data collection and the myriad of other tasks that contribute to the final product. However, without the cooperation of Corrective Services, a project such as this would never pass 'go'. Thank you, Corrective Services Queensland, South Australia, and Tasmania.

Prison research places a considerable burden on practitioners who already have overwhelming caseloads, especially when the prison population being investigated is so vulnerable. Explaining the project to the women on more than one occasion, monitoring their mental health up to the moment of interview to ensure they were willing and able to proceed, accompanying me from one end of the prison to the other, and then sitting down for lengthy interviews of their own, speaks not only to their organisational skills, but to their immense generosity. I trust that their compassion towards the women in their care, along with their knowledge and expertise, are reflected in the pages of this dissertation. Thank you, practitioners.

And now to the beautiful women who are at the heart of this study. I am in the unusual position of being quite lost for words. To *Sally, Belinda, Melanie, Jennifer, Noelene, Alice, Theresa, Rosie, Susan, Kelsey, Caroline, Erica, Molly, Ruth, Amelia, Rachel, Mary, Georgina, Bronwyn, Deidre, Miriam, Renata and Maddie – you are my inspiration. You opened your lives to a stranger and in doing so changed mine. I can no longer view the world through the same eyes. You have reminded me to value what I have, to unconditionally love friends and family, and to respect the freedom be able to chart my own path forward. With all my being, I want the same for you. Thank you. (* Names have been changed to pseudonyms used throughout the dissertation).

How could one ever embark on, let alone complete, this journey without a loving and supportive family? I cannot begin to imagine how impossible that would be. If there was a Nobel Prize for 'support that goes above and beyond', my husband Kevin would be a certain winner. In looking

back, I feel mortified by my expressions of despair and occasional temper tantrums, which he weathered with patience and good humour. I could not have done without his IT wizardry, which made the difference between an intact computer and one destined for the recyclers. Above all, his faith in what I was attempting to achieve never wavered, unlike my own which was regularly AWOL. An amazing person. Thank you, Kevin.

My children (and I know as adults they will find 'children' cringeworthy) are the bedrock of my life. They have taught me that, surprisingly, my opinion is not always the only one. They have taught me to take a step back, to consider the 'bigger picture' that incorporates everything that is not a PhD. Above all, they have taught me how to give in a way that eradicates self-centredness and entitlement. Rather than me teaching them, they have nurtured me in a way that no textbook ever could. Thank you, Daniel and Laura.

I am privileged to have a loving family and circle of friends who have supported me through thick and thin, not only during the PhD process, but over many years. You are my source of strength and I consider myself fortunate to have you in my life. Thank you.

Capstone Editing provided copyediting and proofreading services, according to the guidelines laid out in the university-endorsed national 'Guidelines for Editing Research Theses'.

List of Abbreviations

ABI	Acquired Brain Injury
ADHD	attention-deficit hyperactivity disorder
ADCQ	Anti-Discrimination Commission Queensland
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health and Welfare
ALO	Aboriginal Liaison Officer
ALRC	Australian Law Reform Commission
AWP	Adelaide Women's Prison
BP	Bipolar Disorder
BPD	Borderline Personality Disorder
BWCC	Brisbane Women's Correctional Centre
CJS	criminal justice system
CPS	Child Protection Services
CRPD	*Convention on the Rights of Persons with Disabilities*
CSO	Community Service Order
DVO	domestic violence order
FASD	Fetal Alcohol Spectrum Disorder
HASI	Hayes Ability Screening Index
ID	Intellectual Disability
IQ	Intelligence Quotient
MHWP	Mary Hutchinson Women's Prison
NCID	National Council on Intellectual Disability
NDIS	National Disability Insurance Scheme
NSW LRC	New South Wales Law Reform Commission

ODM	Offender Development Manager
PTSD	post-traumatic stress disorder
QAI	Queensland Advocacy Incorporated
QLD	Queensland
RBMSP	Ron Barwick Minimum Security Prison
RSPCA	Royal Society for the Protection against Cruelty to Animals
STI	sexually transmitted infection
TAFE	Technical and Further Education
TasPol	Tasmania Police
TWCC	Townsville Women's Correctional Centre
WHO	World Health Organization
WWDA	Women With Disabilities Australia

Chapter 1: A Reason to Research

1.1 Background to the study

This dissertation represents both my personal and philosophical approach to cognitive disability, and more specifically, the nexus between cognitively impaired women, their incarceration, and the wider theoretical paradigm of social exclusion. As the parent of an adult intellectually disabled daughter, I understand the concept of 'homogeneity' that is often applied to those with a cognitive disability. And yet I also understand that this is a fallacy. Cognitively disabled people have aspirations and concerns, they can be idiosyncratic, obscure and sometimes challenging to engage with, and each has their own unique life-story. Too often they are placed in a 'category', with an assigned label that determines their opportunities and life chances. Too often this denies them the respect and acceptance that is taken for granted by their non-disabled counterparts.

For people with cognitive disabilities, social inclusion is generally confined to inclusion within their living arrangements and social activities with other cognitively disabled people. Of course there are exceptions, but unfortunately I have witnessed all too often the condescending way in which those with cognitive disabilities are 'managed', particularly at the institutional level. It is demeaning, and yet part of my sadness emanates from the fact that for our daughter and others like her, the reality is one of acceptance that such processes and systems are the norm and awareness that there might be an approach that affords greater dignity and autonomy is either peripheral or non-existent.

I also have firsthand experience of the vulnerabilities that accompany cognitive disability. The potential for our daughter, and others with similar disabilities, to be taken advantage of with a promise of 'friendship' if they are compliant creates constant anxiety that acquiescence will generate antisocial, or worse, criminal behaviour. While this has not happened thus far, it has on several occasions come too close for comfort. The catalyst for this research emanated one Saturday night in Hobart (Tasmania) when for the fifth weekend in a row, members of Tasmania Police (TasPol) returned our runaway daughter to us. Because she was over the age of 18, as her parents we were not permitted by law to in any way insist she come home or get into our car. This could only be done by the police. The two officers were infinitely kind and patient, as had all the other TasPol officers been in the preceding weeks. However, it was clear they were growing impatient with having to assign officers to this task when Saturday evening resources were already stretched to the limit. As they were departing, one of the officers said to our

daughter, “This is the last time we are going to do this. Next time, we will take you to the Remand Centre”. My blood ran cold as I imagined what would happen if this ever transpired. In truth, the statement had no impact on her at all – she had no clue as to what a ‘Remand Centre’ was and so her attitude amounted to ‘whatever…’

The notion of our daughter being held in remand, or worse, incarcerated, raised the question of how women with cognitive disabilities navigate the criminal justice system. Before I began speaking with the exceptional women who contributed to this study, I naively refused to entertain the thought that cognitively disabled women would actually be sentenced to prison. However, this study opened my eyes to the reality that they do end up in prison, most of them on multiple occasions.

It was apparent that while a significant body of research has explored incarcerated males with cognitive disabilities, the question of incarcerated, cognitively disabled women has received less scholastic attention. In the words of Kendall (2004: 265), “The failure to consider women offenders with intellectual disabilities is emblematic of the larger literature”. Statistically, they represent a small percentage of the overall Australian prison population. Each of this study’s practitioner participants acknowledged that a small number is not an excuse for lack of appropriate facilities or programs, but they also pointed out that unfortunately, it is the current reality. This ‘reality’ includes cognitively disabled women with mental illness being housed in secure units, unable to access programs or jobs, or to co-mingle with others. Prison mental health units have extensive waiting lists, and even if some of the women in need are admitted, it will generally only be for one to two days. This does little to elicit any long-term benefit. It is an untenable situation for the women; a frustrating and demoralising one for prison staff.

Tom Shakespeare, a noted scholar and disability activist, supports the notion that disability studies and aligned fields of investigation must be based on sound empirical research, and should not rest upon “slogans, assertions or anecdotes” (2015: 2). An overarching goal is that credible research will act as a conduit to political activism and thereby improved circumstances for people with disabilities because of more effective and enlightened disability politics. There is evidence that politically, the voices of those with disabilities are being listened to. There is a range of state and federal government-supported initiatives premised on reducing the disparities between people with disabilities and those without, particularly with respect to developing a culture of inclusiveness. However, it is evident that many people with disabilities continue to be overlooked because of either not knowing about the services they can access, or not having the support of an advocate to help them do this.

People with cognitive disabilities who are unsupported continually face the reality of social exclusion. Social exclusion is broadly defined as the experience of disadvantage which moves beyond income deprivation to include multidimensional and interrelated factors pertaining to the lack of economic, social, political and cultural participation, which cause disconnection from the wider community (Kostenko et al. 2009). Despite Australia's standing as a First World country, exclusion based on stigma and discrimination, ignorance and fear happens in every state and territory. Incarceration serves to reinforce the barriers to inclusion. For the incarcerated, cognitively disabled women participating in this research, social exclusion manifests as more than just limited access to services. Most of them have never experienced *inclusion,* having lived lives defined by their lack of cognitive and adaptive skills and their status as 'offender'.

Shakespeare's (2015) words struck a chord and brought about the realisation that I could follow his lead. This research therefore emanates from a personal concern that has evolved into a broader disquiet about how we as a society respond to a group of vulnerable women who do not fit the image of the 'ideal victim' (Christie 1986), but fall more readily into the category of 'criminal'. This categorisation is a convenient conduit to notions of 'blameworthiness' and the justification upon which to regard the women as makers of their own destinies and therefore recipients of 'just deserts' (Kirchengast 2010). However, such a linear perspective fails to understand the familial, social, structural, institutional, and cultural forces instrumental in shaping lives marked by exclusionary practices. As you read the women's stories in this dissertation, I hope that like me you will come to appreciate their bravery, be outraged by abuse endured, be enriched by their generous spirit and be moved by their visions of a better future for themselves and their children.

1.2 A reason to research

The purpose of this research is to examine the links between social exclusion, cognitively disabled women, and incarceration and how these intersect to create and perpetuate cycles of disadvantage and offending/reoffending. Using the study's findings, a range of considerations are presented in Chapter 7, highlighting key concerns that emerged while conducting this study. The research is guided by three questions:

1) How does social exclusion contribute to the trajectory of women with cognitive disabilities into prison?
2) How does social exclusion manifest in prison for women with cognitive disabilities?
3) How do prisons respond to the needs of women with cognitive disabilities?

As a starting point, it is important to acknowledge that the experience of incarceration for women occurs within a male-dominated criminal justice system (CJS) that is predominantly based on patterns of male offending, with penal responses framed accordingly (Bartels and Easteal 2016). A similar situation is evident when it comes to the presence of cognitive disability in the CJS. Globally, much has been written about cognitively disabled male offenders (e.g., Barron et al. 2002; Fogden et al. 2016; Lindsay et al. 2008; Morrissey and Ingamells 2011; Murphy et al. 2017). Research involving cognitively disabled women who are incarcerated is limited (Holland and Persson 2011), and yet Australian scholars (e.g., Baldry 2014; McCausland and Baldry 2017; McCausland et al. 2013; McEntyre 2019) highlight the fact that the number of women in prison with cognitive disabilities and co-occurring conditions such as mental illness and substance misuse disorders, has increased exponentially over the past decade.

While these scholars acknowledge this situation, and their work represents a considerable body of research that has done much to advance the cause of prisoners with complex needs, including cognitive disability, the situation remains that research focusing specifically on incarcerated women with cognitive disabilities is sparse. There are only a few dedicated research projects that have sought to address this. Hayes (2007) conducted a relatively small project in the UK, which examined women with cognitively disability in several UK prisons. McEntyre (2019) explored Indigenous women with cognitive disabilities and mental health disorders in New South Wales and Northern Territory prisons. An investigation by Human Rights Watch (2018) looked at prisoners with disabilities in Western Australia and Queensland, but this covered the spectrum of physical and cognitive disabilities and incorporated both men and women. The present study includes Indigenous and non-Indigenous cognitively disabled women, incarcerated in Queensland, South Australia, and Tasmania, and from a jurisdictional perspective is unique. The theoretical framework also sets it apart, with the paradigm of social exclusion distinguishing it from other penological research endeavours.

Addressing this gap in the literature is imperative, as emphasised by Cockram (2005: 172):

> The high rate of females with intellectual disability who are sent to prison at first arrest warrants further research. Historically, there has been little action to identify and address the special needs of women with intellectual disability who offend. This is essentially because women are a minority in a male-dominated system.

This is not always easy. Van Dooren et al. (2016: 14) recognise the challenges associated with prison research, but they also highlight its importance. They argue that “there are multiple barriers to accessing prisoners and ex-prisoners with intellectual disability for research studies,

likely restricting the implementation of evidence-based policy and the establishment of best practice, leaving their voice unheard and specific needs unmet". As Liebling (2014: 481) maintains, "research is reform, or it can be, as we strive to reconceptualise, or articulate, the strange and painful world that is the prison". This then, is a reason to research and a principal driver for this study.

1.3 Making a difference through narrative

When reading the women's stories contained in this dissertation, it is possible readers will feel some of the emotions encountered during the research process and the subsequent writing of the dissertation. There is immense sadness on several levels, not least of which is society's willingness to ignore a situation for which society and its institutions are partially responsible. Most of the women in this study have histories marked by loss and grief, family dysfunction, unstable living arrangements and homelessness, foster care, compromised educational opportunities, abuse in all its forms, self-harm, substance misuse, mental illness, bullying and intimidation, and chaotic lifestyles that contribute to multiple interactions with the CJS.

The study's Indigenous women have experienced the effects of social exclusion built upon a foundation of colonialism and patriarchy. Guthrie et al. (2013), among others, provide evidence for the significant levels of their CJS involvement and rates of imprisonment generated by the causes of social exclusion. These include systemic and institutional racism, stigma, poverty, marginalisation, powerlessness, dispossession and loss of land, welfare dependency, forced separation of family members and dislocation from Elders and communities, and the undermining of self-determining healthcare decisions.

Notably, Guthrie et al. (2013) align the prevalence of children placed in foster care with later-life incarceration. Additionally, time spent in juvenile detention increases vulnerability to adult offending and imprisonment. As noted by Gilman et al. (2015: 33), "once a youth becomes involved in the juvenile justice system, there is a higher likelihood that he/she will remain tethered to the criminal justice system through the transition to adulthood" (also see Halsey and Armitage 2009; McVie 2009). It is also disturbing to note the intergenerational nature of foster care, with the children of several of the women consigned to the custody of Child Protection Services (CPS). It is concerning that both foster care and juvenile detention are not only predictors of adult CJS involvement, but also promote cycles of disadvantage, creating and perpetuating intergenerational social exclusion (Foster and Hagan 2007; Murray 2007).

While the women who shared their stories as part of this research may not necessarily use or understand the term 'social exclusion', they are aware that being overlooked and rejected, bullied, taken advantage of, and pigeon-holed as 'stupid' or a 'retard' is part and parcel of their lives. Some believe they deserve no better; others react with violence, self-harm, or substance use. Into this mix incarceration is added. For a few, prison represents respite from abuse and an opportunity to overcome their addictions. However, they are in the minority. This research demonstrates that for the most part, incarceration reinforces the stigmatised and exclusionary attitudes encountered on both sides of the prison walls.

Does being an offender contribute to exclusion, or does social exclusion lead to offending behaviour and subsequent interaction with the CJS? Realistically this is not an 'either/or' question. The two notions are mutually reinforcing. Cognitive disability is a significant factor. Social use of rhetoric that applauds notions of 'inclusivity' has gained acceptance. Increased political will to improve the lives of those with disabilities through the provision of initiatives in Australia such as the National Disability Insurance Scheme (NDIS) demonstrate government commitment to goals of equality for those with disabilities. However, change is slow when it comes to eliminating the stigma associated with disability, particularly cognitive disability. For those who bear the additional stigma of 'offender', the label is more challenging. Overall, society gives in principle support to improving the lives of the disabled, but the same cannot be said for those exiting prison. Penal populism, embedded by the 1980s, has ensured that the interdependent relationship between politicians and the media effectively casts all offenders as reprehensible. This prompts the creation of more punitive legislation and sentencing laws, longer prison terms for minor offences and a public attitude that supports long-term incarceration (Roberts and Indermaur 2007; White et al. 2019). It is little wonder that if/when women with cognitive disabilities exit prison, opportunities for a life that is socially inclusive are virtually non-existent (Queensland Advocacy Incorporated [QAI] 2015).

Prisons are primarily concerned with security, risk management and the maintenance of rules and regulations. Liebling (2014: 482) asserts that "When we conduct social science research in criminal justice settings, we enter a world in which power flows overtly". She draws attention to the credibility imbalance between incarcerated people and the authority figures who surround them:

> The question of whose account can be trusted is loaded in favour of the superordinate and against the subordinate in an especially marked way, as evidenced by the frequency of the challenges prison researchers face to their narratives of prisoners' lives and experience, as well as the lack of challenge to the official narratives embedded in day to day operational practice (Liebling 2014: 482).

She goes on to argue (2014: 483), "prisons are primarily about extreme and varying uses of power and authority, as well as about complex social organisation and punishment practices". They are not, as some politicians would have us believe, a therapeutic space that offers a supportive environment to those with cognitive disabilities and mental health impairments (Rowe et al. 2017). Within women's prisons, there might be tacit recognition of cognitive disability, but there is neither the time nor the resources to fully evaluate this or provide any substantive support that seeks to prioritise cognitive and adaptive skills. Despite the stated aims of Corrective Services, such as those in South Australia, that seek to "improve outcomes for offenders through measures to reduce recidivism and provide successful reintegration back into the community" (South Australian Department for Corrective Services 2017: 4), such an objective is not without its obstacles when considered in the light of the women in this study. They have complex needs, of which cognitive disability is a component. There is a wealth of empirical evidence highlighting the challenge of managing prisoners with complex needs and cognitive impairments (e.g., Baldry 2009; Baldry et al. 2012; Cunneen et al. 2013; New South Wales Law Reform Commission [NSW LRC] 2012; Rowe et al. 2017). However, this increase in understanding of the disability-related support needs of cognitively impaired women in prison is yet to translate into evidence-based holistic approaches. Women's needs are multifarious: substance misuse, mental and physical health, and life-skills are just some of the areas requiring support. Above all, any approach must be trauma-informed in recognition of the impact of past and present trauma, including incarceration (Baldry 2010; Carlton and Segrave 2011; Segrave and Carlton 2010).

The women in this study reflect the wider prison population in that 'incarceration begets incarceration'. They are frequently targeted by police, and police cautions are uncommon. They are less likely to receive bail or be granted parole (Cunneen et al. 2013; Gray et al. 2009; Shepherd et al. 2017). Incarceration exacerbates challenging behaviours and contributes to deteriorating mental health (Cockram 2005). They are vulnerable to coercion and manipulation by other prisoners as well as bullying and victimisation (Corston 2007; Easteal 2001; Hayes 2012; Holland et al. 2002). Post-prison, they are at risk of homelessness and unstable living arrangements, including a return to abusive environments and/or criminogenic peer and family relationships that may have contributed to their imprisonment in the first place (Baldry 2010).

Rowe et al. (2017: 21) argue that "this population is frequently excluded from mainstream services as a consequence of both their disabilities and their offending behaviours making it vital to provide holistic disability support to prevent offending and re-offending". Upon release from prison, the presence of a cognitive disability is surpassed by their criminality, and the fact

that they have other comorbid conditions contributes further to their inability to access supports and services. This is because in general, service delivery requires the recipient to seek out a provider. As Clift (2014) points out, it is unrealistic to believe that this population group is equipped to manage that process. For a start, people with cognitive disabilities must self-identify the presence of a disability and what this implies in terms of the type of support they require (Churchill et al. 2017). Additionally, the very nature of institutionalisation (in this case, prison) undermines initiative and decision-making capabilities. Paired with compromised cognitive function, the women in this study are ill-equipped to seek out the people and services that may be able to help them (Clift 2014; Churchill et al. 2017; Rowe et al. 2017). Pre-release planning goes some way to assist but relies heavily upon the person initiating processes once they are released. Even if this is somehow achieved, the study's participants then need to follow the advice that is provided (e.g., health care) which often does not happen (Churchill et al. 2017).

A certain degree of ethnographic participant observation informs this dissertation. I have been closely involved with the disability sector for many years as part of navigating the route of a parent to an intellectually disabled child, in addition to years of volunteer work in various capacities, such as coaching Riding for the Disabled, as well as program delivery within prisons. This has profoundly supported the level of insight and contextualisation possible in the dissertation. Rather than the research being a linear academic exercise examining cognitive disability and incarceration from a distance, being a part of both worlds has allowed this dissertation to evolve into a more heterogeneous and ultimately more interesting study as it seeks to understand these complex intersections.

1.4 Dissertation structure

This dissertation argues that incarcerated women with cognitive disabilities are socially excluded prior to incarceration and within the prison setting, and that prisons are under-resourced to provide support. As the study's findings indicate, incarceration is a primary determinant of social exclusion, but the reverse is also true: social exclusion contributes to incarceration. In this chapter, the key objectives of the study have been presented and the background to the research explained, along with an overview of the issues pivotal to the incarceration of cognitively disabled women and their significance to the study's central argument.

Chapter 2 examines the literature around focal areas of the dissertation with ongoing debates about the role of deinstitutionalisation prefacing this discussion. The chapter also provides

definitions of cognitive disability in the context of this research and explanations of other relevant terminology and language including dual diagnosis, complex needs and challenging behaviour. Goffman's (1963) seminal work on stigma as a cause and effect of social exclusion provides a key theoretical perspective. The concept of 'intersectional stigma' is used to illustrate the link between stigma and social exclusion.

An examination of social exclusion is introduced by turning to Foucault's *Madness and Civilisation* (1965), predicated on the exclusion of society's unwanted by consigning them to institutions. Linking Foucault's theoretical paradigm with 21st century pragmatism, a discussion of social exclusion directs the reader to move beyond traditional concepts of poverty and income deprivation to consider a multidimensional approach that incorporates social and structural factors. Access and barriers to justice are examined, as well as the juxtaposition of prison as simultaneously an institution of control and a place of refuge.

Chapter 3 presents the study's methodology and research design. This includes the research questions, aims and objectives and the reasons for using a narrative approach. Central to this chapter is an explanation of the utility of social exclusion as a paradigm that supports this study. Emerging themes are considered in the context of Lafferty et al.'s (2016) social inclusion/exclusion framework, developed to reflect the prison setting. Sampling procedures, data collection and analysis are described. Ethical considerations and the challenges and limitations of the research are also discussed.

Chapters 4, 5 and 6 present the study's findings. In sharing the women's stories of their lives prior to incarceration, Chapter 4 provides the foundation for a response to Research Question 1. It explores the ways in which social exclusion has shaped the lives of the participating women prior to incarceration. As this chapter highlights, the role of trauma is central, and is responsible for behaviours such as substance misuse, directly contributing to CJS interactions.

Chapter 5 builds upon the findings of Chapter 4 and provides the evidence necessary for responding to Research Question 2. It investigates the women's pathways through the CJS and the barriers to justice they face at every stage. Notions of over- and under-policing, confusing court processes and issues of remand, bail and parole are explored, with the voices of the women pivotal. This chapter also examines the notion of prison as a place of 'refuge'.

Chapter 6 examines the needs of the women in this study and prison responses to those needs. The narratives of prison practitioners reinforce many of the issues identified by the women in Chapters 4 and 5. Practitioners emphasised that prison is not the right setting in which to deal with the trauma that accompanies the women into prison, despite the stated role of the prison

as a place of rehabilitation. This chapter highlights the subordination of rehabilitative and therapeutic goals to prison objectives of containment and security.

Chapter 7 draws together the findings of the previous three chapters and provides responses to each of the dissertation's research questions. These responses evolve from the extant literature and this study's data. Using these results, a set of models are created that demonstrate the links between the domains of social exclusion described in Chapter 3 with the evidence-based needs of the women identified in Chapter 6. Over and above the interrelated nature of social exclusion, these models illustrate that by addressing the women's needs, positive interventions within each domain of social exclusion transpire. The chapter also includes some key considerations arising from the women's narratives that bring into focus their lived experiences and the fact that cognitive disability continues to be punished. The chapter concludes by offering theoretical reflections arising from this study and directions for future research.

*Appendix 5 provides biographies for each of the 23 women who participated in this research. These stories provide the context for the narratives embedded in Chapters 4 and 5.

Chapter 2: Complex Intersections: Cognitive Disability, the Criminal Justice System and Social Exclusion

2.1 Introduction

The purpose of this chapter is to examine the extant literature and conceptual foundations of this dissertation to provide context for its central objective; that is, to examine the links between social exclusion, women with cognitive disabilities, and incarceration, and how they intersect to create and perpetuate a cycle of disadvantage and offending/reoffending. The task of reviewing the relevant scholarship was formidable, given that this study links together key concepts that independently form a substantial body of work. Drawn together, they represent an interwoven theoretical landscape that negotiates issues of social exclusion such as deinstitutionalisation, stigma, cognitive disability, incarceration and women prisoners. As the title implies, the structure of the chapter both separates and unites the individual concepts that influence the study's theoretical framework and contribute to addressing the research questions. Notwithstanding this, literature focusing on incarcerated women with cognitive disabilities is limited, particularly in the context of social exclusion. Bigby (2012) notes that this lack of scholarly attention means there is little empirical evidence upon which to base planning of possible programs or decisions related to psychosocial and therapeutic interventions that will support social inclusion.

This chapter commences by providing definitions for, and explanations of, the terminology used throughout the dissertation. A brief description of social exclusion is presented, with the concept considered in greater detail later in the chapter. While acknowledging that 'cognitive disability' encompasses a wide range of disorders, explanations will be limited to the cognitive disabilities that apply to the research population. The terms 'comorbidity', 'dual diagnosis' 'complex needs' and 'challenging behaviours', are explained and distinctions between mental health disorders and cognitive disabilities considered.

An examination of deinstitutionalisation follows, contextualising the use of social exclusion for the dissertation's theoretical framework. Beginning in the 1960s and still ongoing, deinstitutionalisation has created philosophical divisions in academia, human services and criminal justice agencies. Proffered as a move towards the social inclusion of institutionalised men and women, it has, in some instances, achieved the opposite. The underlying reasons for this will be discussed.

In the study's exploration of social exclusion, Goffman's (1963) work on stigma makes an important contribution. The notion of intersectional stigma (Gunn et al. 2018; Turan et al. 2019) is considered from the perspective of its relevance to the women in this study. Following this, a comprehensive review of social exclusion and its applicability to the current project is presented. In addition to Goffman's influential work on stigma, his earlier work (1961), as well as that of Foucault (1965, 1977), analysing the exclusionary nature of institutions, particularly prisons, make a significant contribution to the study's theoretical underpinnings.

Finally, scholarship investigating 'pathways to prison' via the various agencies of criminal justice are reviewed. Here, the symbiotic relationship between social exclusion and the CJS is highlighted with a focus on cognitive disability. Challenges in accessing justice and punishment based more on social/structural issues, rather than actual offending, are assessed. A lack of agency, along with cognitive disability, substance misuse disorders and compromised physical and mental health, reinforce social exclusion and susceptibility to CJS interactions. The chapter concludes with a summary of the key points.

2.2 A brief summary of social exclusion

Because the term 'social exclusion' is used frequently and is a fundamental tenet of this dissertation, a preliminary explanation of what it means is warranted. This will be developed in more detail later in the chapter. The many debates about definitional issues demonstrate the political and social concern that affects individuals and communities globally (Peace 2001; Saunders 2011). This dissertation utilises explanations of social exclusion that adopt a relational approach, thus shifting the perception beyond definitions of social exclusion premised on poverty to consider social, structural and cultural dimensions that are fundamental to a person's potential to be socially included.

Levitas et al. (2007: 25) have constructed a definition of social exclusion that incorporates many of the factors identified in the social exclusion literature:

> Social exclusion is a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole.

Of significance to this study is the fact that cognitive disability is a recognised cause of social exclusion (Corbett 2011). Peace (2001: 33-34) offers an insightful explanation of social exclusion when she talks about the "linked and cumulative factors and processes that confound

individual and group capacity for hope, opportunity, reciprocity and participation". These attributes encapsulate what it means to be 'socially included'. However, as this study reveals, for the women participants, there is a paucity of hope, opportunity, reciprocity and participation.

2.3 Cognitive disability and women in prison

'Cognitive disability' is a broad term that encompasses "all impairments that may affect cognition" (McSherry et al. 2017: 10; also see Jones and Talbot 2010; Thomas 2007; NSW LRC 2012). While recognising that there are many more conditions than those listed here, the discussion will be confined to the disorders identified by prison practitioners participating in this research that apply to the women being investigated:

- Intellectual Disability (ID)
- Acquired Brain Injury (ABI)
- Fetal Alcohol Spectrum Disorder (FASD)

Such impairments manifest as continuing deficiencies in comprehension, reasoning skills, judgement, learning or memory (Baldry et al. 2015; Whitaker 2013). Apart from ABI, all are present before the age of 18.

2.3.1 Intellectual Disability (ID)

ID is most commonly associated with genetic conditions such as Down Syndrome, Fragile X Syndrome or Rhett Syndrome; problems during pregnancy (e.g., exposure to toxins); problems at birth (e.g., lack of oxygen); health problems during pregnancy (e.g., measles); and environmental factors (e.g., exposure to lead or mercury, lack of proper medical care, or malnutrition). ID cannot be cured, but as various organisations and scholars note, appropriate and timely support will assist people to lead productive and enriched lives (Ellem et al. 2012; Holland 2008; Villamanta Disability Rights Legal Service 2012).

2.3.2 Acquired Brain Injury (ABI)

ABI is damage to the brain occurring after birth. It is typically caused by accidents, infections, stroke, substance abuse, or neurological diseases (such as meningitis or encephalitis). ABI generally manifests as difficulties in cognitive functioning (Dowse et al. 2009) and may also impact emotional regulation and physical capabilities (Famularo 2011; Jackson et al. 2011). However, as Winford et al. (2012) identify, ABI does not always impact intellect or physical appearance, creating challenges in terms of diagnosis. It is sometimes referred to as the 'invisible' disability (Brain Injury Australia 2007).

2.3.3 Fetal Alcohol Spectrum Disorder (FASD)

FASD causes brain damage arising from prenatal exposure to alcohol. This results in poor physical growth, facial abnormalities and central nervous dysfunction (Burd et al. 2010). FASD causes life-long brain impairments: learning disabilities, poor impulse control, poor decision-making capabilities, violent behaviour, physical and mental health problems, and also substance misuse (Birgden 2016).

While each of these conditions are recognised in the area of cognitive disability, several scholars and policy documents (e.g., NSW LRC 2012; Hatton 2012; Lamb 2012), highlight the challenges presented by jurisdictional (and even prison to prison) definitional differences. For example, some only consider Intelligence Quotient (IQ) scores while others include adaptive functioning measures. Variations in prison approaches extend to other issues such as differences in assessment tools, the level of expertise of those conducting the test and whether assessments are performed individually or in a group situation. In the prison setting, measuring IQ is problematic. Tests are time-consuming and require specialised training to administer. With prison resources under pressure, IQ testing not routinely employed (Nixon and Trounson 2017). The specificity of a definition also has bearing. A broad or vague definition will result in greater estimates of cognitively impaired people in contact with the CJS, while a more precise definition will produce a lower estimate (Hatton 2012).

2.4 Cognitive disability or mental disorder?

'Mental disorder' is a diagnostic term employed by psychologists and psychiatrists, and generally includes disorders such as anxiety, depression, borderline personality disorder, substance use disorder, schizophrenia and psychosis (NSW LRC 2013). In general, it falls within the area of health and illness. Cognitive disability, as described above, incorporates impaired intellectual functioning and limited adaptive skills such as self-care, living safely in an independent environment, healthcare and social skills.

The conflation of 'cognitive disability' and 'mental disorder' means that cognitively impaired offenders are sometimes treated the same as those with mental health conditions (Baldry et al. 2012, 2013; Hamilton 2010; NSW LRC 2013). In Australia, offenders with cognitive impairment have generally been managed under mental health legislation (Baldry 2014; Baldry et. al. 2008). This often means that cognitive disability is regarded as an illness, comparable to a mental health condition, with treatment being the same for both (NSW LRC 2012). This issue was highlighted in the 2006 Carter Report, which called for a different response to people with

a single diagnosis of cognitive/intellectual disability who, if diverted from the CJS, were routinely accommodated in secure mental health units. QAI (2016), among others, regard the conflation of mental illness/cognitive disability as a serious issue in the CJS, noting inappropriate responses to cognitive disability, such as detention in forensic facilities.

2.5 Comorbidity, dual diagnosis and complex needs

Comorbidity is a clinical term that denotes the coexistence of more than one problem or disorder affecting the life of an individual. It most commonly refers to the coexistence of one or more types of mental illness (e.g., anxiety disorder and schizophrenia) in conjunction with substance misuse/addiction and may also include physical conditions (Australian Institute of Health and Welfare [AIHW] 2018). In Australia, dual diagnosis is customarily used to include a mental health problem or disorder leading to, or associated with, problematic alcohol and/or other drug use, or a substance use disorder leading to or associated with a mental health problem or disorder (Senate Select Committee on Mental Health 2006).

While comorbidity and dual diagnosis are prevalent in in women's prisons (Blaauw et al. 2015; Scott et al. 2008; Zlotnick et al. 2008), many women have multiple issues impacting their ability to function normally. 'Complex needs' is a broader, less clinical term that captures various combinations of social difficulties and inequalities, behaviours and experiences (Peters et al. 2015; Carney 2006). Complex needs can present with various combinations of mental illness, cognitive disability, ABI, behavioural difficulties and criminogenic factors such as homelessness, education deficits, social isolation or inappropriate peer networks, family dysfunction, and drug and/or alcohol misuse (Hamilton 2010; Peters et al. 2015; Oakes and Davies 2008; Emerson 2008; Dickson et al. 2005; Ellem et al. 2012; Dias et al. 2013; Dias et al. 2014).

2.6 Challenging behaviour versus offending behaviour

A 'challenging behaviour' is one that society in general finds difficult to accept. It challenges our ability to understand why it is happening, usually because it contravenes unwritten (but commonly acknowledged) social rules (Poppes et al. 2016). Impulse control and emotion regulation, along with little comprehension of action versus consequence, contribute to perceptions of challenging behaviour (Kelly and Winkler 2007; Royal College of Psychiatrists et al. 2007). Physical aggression is the most common and frequent type of challenging behaviour exhibited by people with cognitive disabilities (Hayes 2004; Lunsky et al. 2012).

In the context of the prison, women with cognitive disability and challenging behaviours are regularly subjected to some form of sanction such as solitary confinement. For example, Human Rights Watch (2018) report that women with cognitive disabilities who exhibit challenging behaviours are overrepresented in detention (punishment) units and viewed as a management issue, as opposed to someone with complex needs requiring appropriate mental health interventions (also see Douds and Bantwal 2011; Kozma et al. 2009; Spivakosky 2013).

2.7 Deinstitutionalisation in Australia

Goffman's (1961) seminal work examining psychiatric asylums investigates the nature and effects of institutionalisation and the way in which it socialises people into the role of being a 'good' patient; that is, someone who is "dull, harmless and inconspicuous" (1961: 164). Goffman (1961: 4-5) locates the asylum within the space of what he calls "total institutions"—a class of institutions that includes the prison, the gaol, sanitaria and leprosaria, and almshouses for the poor and infirm, in addition to army barracks, boarding schools and monasteries (Pilgrim and Rogers 2008; Gambino 2013). As Mac-Suibhne (2011: 2) argues, "his [Goffman's] most mordant observations are on the dehumanising effect of not only institutionalisation, but any social system that reduces some individuals to a role".

Goffman's (1961) essays were instrumental in generating the winds of change. The 1960s and following decades witnessed an increase in negative publicity surrounding the institutionalisation of people with cognitive disabilities and/or mental health problems (Young et al. 1998; Simpson 2018; Wiesel and Bigby 2015). Publications such as Blatt and Kaplan's (1966) photographic essay on the living conditions of institutionalised intellectually disabled people generated widespread public outrage, prompting governments and relevant organisations to act swiftly. The response was one of 'normalisation', with the provision of residential services in community-based homes providing a lifestyle as close to 'normal' community living as possible (Bigby and Fyffe 2006). Deinstitutionalisation was heralded as a vehicle that would potentially increase residents' adaptive behaviours, decreasing their likelihood of being abused and neglected (Conway et al. 1996).

In Australia, the move to implement deinstitutionalisation received in-principle support politically and from human services agencies, mainly in recognition of the spiralling costs associated with "humanising institutions" (Bigby and Fyffe 2006: 567). However, in areas where the closure of an institution was not supported by a corresponding escalation in community-based resources, a proportion of people released from such institutions became vulnerable to unstable living arrangements including homelessness (Baldry 2010; Baldry and

Maplestone 2003; Cunneen et al. 2013; Hamilton 2010). Additionally, links between the deinstitutionalisation of people with comorbid and complex needs and increased rates of their incarceration came to light (Baldry et al. 2012). 'Deinstitutionalisation' became synonymous with 'alternative institutionalisation' as those with cognitive disabilities came to the attention of criminal justice agencies (Beadle-Brown et al. 2007; Hayes 2004; Mansell and Beadle-Brown 2010).

2.8 Goffman, stigma and setting the scene for social exclusion

Goffman's influential work *Stigma. Notes on the Management of the Spoiled Identity* (1963) references people with disabilities. Based on experiential accounts, Goffman presents an analysis of the behavioural responses of 'normal people' to those possessing discrediting features – that is, individuals whose 'actual' social identities do not match the 'virtual' social identities expected of them. While there are varying definitions of stigma, the concept reduces the bearer from "a whole and usual person to a tainted, discounted one" (Goffman 1963: 3).

It would be unfair not to acknowledge that in many parts of the world, attitudes to people with cognitive disabilities have improved as a result of disability advocacy, as well as scholars such as Shakespeare (2015) and Thomas (2004, 2006, 2007) whose work has done much to advance the cause of those with disabilities. However, Scior (2016) points to studies that conclude that cognitively disabled people continue to occupy a position near the bottom of the social hierarchy (e.g., Jahoda and Markova 2004). Neuberg et al. (2000) contend that as long as cognitive disability is considered a factor that inhibits a person's ability to make a contribution to society, it will continue to be stigmatised (also see Appleton-Dyer and Field 2014; Jahoda et al. 2010; Gooding et al. 2017; Taket et al. 2009). Hall's (2004, 2005, 2010) findings conclude that even when cognitively disabled people are physically included within communities, socially and culturally they continue to feel unwelcome and rejected, leading to limitations on their participation within certain spaces. Additionally, paternalistic attitudes have led to restricted choices and rights for those with cognitive disabilities, such as the erosion of independent decisions regarding lifestyle, marriage, and children (Ditchman et al. 2013; Ditchman et al. 2016).

2.9 Intersectional stigma

'Stigma' is typically used as a blanket term to cover a variety of discriminatory processes. However, its relevance to this dissertation needs to be analysed in the context of the participating women. For them, stigma is multifarious, or intersectional. 'Intersectional stigma'

is a term that emerged to characterise the convergence of multiple stigmatised identities based on gender, race and/or social class, as well as factors such as incarceration, mental illness, disability and substance misuse (Gunn et al. 2018; McCall 2005; Remedios and Snyder 2018; Turan et al. 2019). Using an intersectionality lens, the following discussion examines the issue of multiple stigmas. Behavioural-related stigmas, such as substance abuse and incarceration, are compounded by race and class-based stigmas, as well as those associated with mental illness and disability, homelessness and various 'stigma combinations', such as incarcerated women who are mothers, and mothers who are cognitively disabled. What emerges from this exploration of stigma is an appreciation of the challenges to identity faced by the women in this study on a daily basis, and the barriers to inclusion arising from the damage caused when the 'convergence of stigmas' becomes the 'collision of stigmas'.

2.9.1 Women with cognitive disability

A significant body of research concludes that women with cognitive disabilities face both gender-related and disability-related discrimination (Dowse et al. 2016; Emmett and Alant 2007; Habib 2010; Moodley and Graham 2015; Parker et al. 2007; Thomas 2006, Women With Disabilities Australia [WWDA] 2009). They are more likely to experience economic hardship than men with cognitive disabilities. They are disproportionately vulnerable to multiple forms of violence, abuse (including sexual assault) and exploitation at home, at work and in the community (Charlesworth 2013; Frohmader et al. 2015; Mays 2007; Meekosha 2004; Nixon 2009; Thiara 2011). Swift (2013) maintains that while these experiences may mirror those suffered by other women, the vulnerabilities associated with their disability are heightened by their situation of social disadvantage, welfare dependence and cultural devaluation.

2.9.2 Mental illness

Despite extensive media campaigns and public awareness of mental illness, those affected continue to be stigmatised. People with mental illness remain one of the most socially excluded groups, with significant disparities in areas such as health, housing and employment (Boardman 2011; Ditchman et al. 2013). Many feel that they cannot be a part of their local community and are, in fact, unwelcome (Boardman 2011). As Merton and Bateman (2007: 11) argue:

> It is not the diagnosis of a mental health issue that leads to stigmatisation and consequently to social exclusion. Rather it is the manifestation of societal ignorance and fear about mental health issues that produce these outcomes. Stigma and social exclusion are fed by anxious, insecure, and prejudiced communities which do not tolerate difference.

The issue of gender features noticeably in the acceptance of mental illness, where women face unique barriers (Mizcock and Russinova 2015, 2016). Women with co-existing mental illness and cognitive disability are consistently found to be the least socially accepted in relation to other disability groups (Baumann 2007; Ditchman et al. 2013; Miller et al. 2009).

2.9.3 Substance misuse disorders

Various studies conclude that substance use disorders continue to be highly stigmatised (Room 2009; Heijnders and Van Der Meij 2006). Such disorders are mostly treated as a criminal rather than a health issue, particularly in the case of illegal substances, which not only draw social disapproval but further the cycle of stigmatisation via the criminalisation of substance-using behaviours (Livingstone et al. 2011). Issues of addiction lead to marginalisation, ostracism and devaluing of certain groups and individuals (Buchanan and Young 2000; Livingstone et al. 2011), particularly when viewed as a moral deficit, whereby the person is tasked with 'fixing' it (Livingstone et al. 2011).

2.9.4 Homelessness

Stigmatisation effectively excludes those who are homeless from social approval (Goffman 1963). Society is adept at blaming the individual for their state of homelessness, rather than the social, structural and economic influences that create and maintain conditions of inequality (Belcher and DeForge 2012). Homelessness is attributed to factors such as substance abuse, with those who are homeless cast as masters of their own destiny. They are invariably referred to by their assigned label – homeless – and often perceived as threatening or dangerous, thereby reinforcing their social identity and maintaining the separation of 'us' and 'them' (Belcher and DeForge 2012; Horsell 2006; Takahashi 1997). Horsell (2006: 213) argues that within the Australian context, "homelessness has been profiled as one of, if not the, most significant forms through which individuals are excluded socially".

2.9.5 Incarceration

In Australia, the overuse of incarceration as a method of control in the wake of more punitive attitudes towards punishment has given rise to a dramatic increase in the number of incarcerated women (Hislop 2019). As Guthrie et al. (2013) highlight, the stigma associated with labels such as 'offender' contribute to pre-existing stigmatisation and exclusion arising from a state of disadvantage. They are often marginalised via restricted access to housing, employment and community participation post-release, and to their families and children while incarcerated (Moore et al. 2016; Moran 2015; Rowe 2011). Cherney and Fitzgerald (2016) maintain that

being incarcerated delivers an apparent message about 'untrustworthiness' and potential for future criminality (also see LeBel 2008, 2012; LeBel and Maruna 2012; Forman 2017; Opsal 2012).

The stigma associated with incarceration serves to exacerbate low self-esteem, guilt, anger, shame and dependency. This has implications for women exiting prison who are more likely to return to communities feeling helpless and in danger of being socially excluded (Dodge and Pogrebin 2001; Fortune et al. 2010; Gunn et al. 2018; Maidment 2006; Pickering 2014; Pollack 2008, 2010). Van Olphen et al. (2009) argue that the very conditions facing those who exit prison, shaped by exclusion and stigmatisation, are typically the same ones that led to their incarceration in the first place.

2.9.6 Incarcerated women + motherhood

There is considerable scholarship around the subject of incarcerated women who are mothers (e.g., Allen et al. 2010; Berry and Eigenberg 2003; Garcia 2016; Shamai and Kochal 2008). A focus of this scholarship is the loss of social relationships because of incarceration, and more particularly, an emphasis on the identity of being a mother (Dodge and Pogrebin 2001). As Corston (2007) maintains, to be put in prison is essentially to be cast as a 'bad mother' in the eyes of the broader community. The fact that poverty, racial discrimination, trauma and poor education are most often central to their imprisonment is overshadowed by a maternal identity that is tarnished because of imprisonment (Baldwin 2019; Salisbury and Van Voorhis 2009). Aiello and McQueeney (2016) maintain that while incarcerated mothers are by no means the only stigmatised group of mothers, they are nevertheless among society's most excluded women (also see Burgess and Flynn 2013).

2.9.7 Mothers with cognitive disability

A further layer of stigma extends to mothers with cognitive impairment. While there is limited research on parenthood and cognitive disability, "anecdotal evidence suggests discriminatory attitudes and widely held prejudicial assumptions that question women's ability and, indeed, their right to experience parenthood" (Frohmader and Meekosha 2012: 297). Patriarchal beliefs that women with cognitive disabilities are 'naturally' inappropriate to be a mother severely undermine their role as parents (Malacredia 2009; Baum and Alexander 2010). Tarleton et al. (2006) argue that parents with cognitive disabilities often come to the attention of CPS simply because it is assumed they will neglect their children, even though there may be no evidence to support this (also see Lamont and Bromfield 2009; McConnell and Llewellyn 2010a, 2010b; Renwick 2012; Swain and Cameron 2010). As Glaun and Brown (2009: 95) state,

'inappropriate parenting' more often arises from the "cumulative weight of stressful emotional, physical and social factors" which need to be considered as much as impaired cognitive functioning (also see Baum 2014).

2.9.8 Indigenous status

It is beyond the scope of this dissertation to provide a thorough analysis of the ongoing societal and institutional stigma felt by many of Australia's First Peoples. It is a topic deserving of more coverage than that offered here, but any analysis of stigma and discrimination would be incomplete without acknowledging their impact on Indigenous communities more broadly and the Indigenous women in this study specifically. Colonisation was, and continues to be, a disabling experience for First Peoples (Cunneen et al. 2013; Meekosha 2011). Dispossession, loss of cultural identity, the impact of the Stolen Generations, forced removal of children, and continued institutional and social discrimination are still embedded in many communities (Baldry and Cunneen 2014; Peterson et al. 2008). Research conducted by Hinton et al. (2015) highlights the fact that stigma associated with Indigenous mental illness and substance misuse not only contributes to a downward spiralling of mental and physical health, but also acts to prevent many from accessing appropriate services. Baldry and Cunneen (2014) point to the over-incarceration of Indigenous women with cognitive disabilities and the fact that they are the most rapidly growing Australian prison population.

2.9.9 Stigma and social exclusion

Stigma has been described as a core domain of social exclusion (Social Exclusion Unit 2004). Gordon et al. (2017: 58) refer to the "vicious cycles of social exclusion" which they link with "vicious cycles of discrimination". They identify institutions, government agencies and society more broadly as being drivers of social exclusion. According to Major and Ecclestone (2005), stigma-based exclusion is particularly insidious because it is consensual; that is, there is general agreement within a society that people and groups with certain traits should be excluded. Stigma-based exclusion is vindicated because of an understanding that it is 'reasonable' (also see Thornicroft et al. 2008).

2.10 From Goffman to Foucault: Social exclusion, prisons and disability

Foucault's *Madness and Civilisation* (1965) is substantially based on the historic reality of social exclusion. The use of asylums served a dual purpose: a place to 'cure' the insane and as protection for society. Places of exclusion therefore became places of 'treatment'. This concept permeated much of his work during the 1960s and 1970s when he advocated for incarcerated

people and homosexuals as the victims of exclusionary practices by French society (Peters and Besley 2014). His analysis was underpinned by an inclusion/exclusion binary and the processes of social construction that "discursively created human beings as subjects or non-subjects, as human or something less than human, as abnormal" (Peters and Besley 2014: 101).

These institutions were, according to Foucault (1965, 1977), connected by regulated modes of discipline to create compliant "docile bodies" (1977: 138-139) achieved via interventions by psychologists, medical staff and prison officers. Foucault was interested not just in tracing the evolution of the prison, but also examining the question of what prisons reveal about the society that exists outside its walls (Lumby 2002). Foucault argued that 'better' prisons, or even the abolition of prisons, does not mean that exclusion and marginalisation will simply disappear. Society will create other ways to isolate sections of the population. All the social antagonists highlighted by Foucault (e.g., normal/abnormal; mad/reasonable) remain both inside and outside the prison (Cattuci 2018).

2.11 Bio-power and a response to Foucault

More recently, Foucault's philosophies have been used as a prism through which to view disability. Various authors (e.g., Allen 2005; Anders 2013; Hughes 2005; Tremain 2005) have responded to Foucault's call to examine what has traditionally been considered 'normal' or 'preordained'. Foucault's (1978) work on bio-power/bio-politics is particularly relevant. Based on Foucault's ideas regarding practices of division and classification aimed at controlling social anomalies, Tremain (2005) points to the expansive apparatus that has evolved. This includes specialised homes and institutions, special education programs and sheltered workshops created to secure the 'well-being' of those with disabilities. However, this approach to disability generates an argument that any paradigm into which people are initiated and separated from others enhances the cultivation and augmentation of exclusionary practices (Anders 2013; Carling-Jenkins 2014; Spivakosky 2013; Tremain 2017), a position informed by Foucauldian perspectives.

Foucault (1977) maintained that prisons operate as a rational power-knowledge mechanism working within broader policies of domination and subjectification, essentially permitting upper classes to continue the suppression of the lower classes (Massa 2016; White and Perrone 2015, 2019; White and Haines 2008). In addressing the power-knowledge binary, Foucault (1980) derives insight from Marxist-inspired discourses that examine the manner in which society's middle/upper classes, who commonly uphold the principles and modes of wealth creation, exclude those who do not fit within this model. Based on this approach, social

exclusion is regarded as a choice and arises from individual deficiencies, rather than social, structural, political and economic forces. Entrenched cultural codes that mandate a broadly accepted ideology of individualism ensure that the socially excluded remain as such - excluded. Even treatises proffered by welfare bodies, which express a desire to change the circumstances of those most affected by social exclusion, are fortified by power relations that serve to pathologise and reinforce official constructions of lives marked by disadvantage (Horsell 2006).

However, Baldry's (2009) examination of patriarchy, and its application to institutions and vulnerable people, contests the Foucauldian analysis of institutions and control. While recognising the value of Foucault's theoretical contributions regarding institutionalisation as a societal response to 'difference', she maintains that Foucault did not address the crucial roles of patriarchy and colonialism as key contributors to the incarceration of vulnerable people in prisons cast as the "last institutions in Australian society in which to control and accommodate Indigenous women and those with serious disadvantage, comorbidity and dual diagnosis…" (p. 28). Baldry (2009: 28) suggests the need to "move into a post-Foucauldian theorising phase" in order to provide a refreshed approach to the "reinvented institutions of the 21st century" which she argues are a "manifestation of patriarchal colonialism."

The merit of this argument can be seen in a CJS that disproportionately affects Indigenous people and those with disabilities, particularly cognitive disabilities. As Brennan (2016) notes, this is a system that for the most part, has failed to adapt and respond to the complex needs of people with cognitive disabilities and/or mental health disorders and ultimately 'punishes disability' because it is mistaken for disobedience (also see Spivakosky 2014). Legislative frameworks are both inflexible and inadequate, and constricting sentencing practises limit judicial discretion, denying the court's ability to allow for individual circumstances.

Despite these reflections on what might be termed 'Foucauldian shortcomings', his philosophies continue to resonate, and there is considerable 21st century scholarship that draws upon his work. For example, when considering the question of *who* has the power to include/exclude, Boardman (2011: 113) argues that "exclusion can be seen as the outcome of the system, with components of society, intentionally or unintentionally, acting as the excluding agents, including political, economic and social institutions.". The late Ronald LaBonte, a noted scholar in the field of social exclusion, was forthright when he summarised the condition of 'being excluded' and its relationship to power/powerlessness:

> Social inclusion/exclusion is more interesting and dynamic than either social cohesion or social capital, for it is poised on the very contradiction evinced by all of these terms: how does one go about including individuals and groups in a set of structured social relationships responsible for excluding them in the first place? Or, put another way, to what extent do efforts at social inclusion accommodate people to relative powerlessness rather than challenge the hierarchies that create it? (LaBonte 2004: 117)

LaBonte's (2004: 117) list of 'the excluded' is "anyone who is not a white, middle-aged, middle-incomed male." (Foucault would undoubtedly have placed 'heterosexual' on the list.) People who feature on LaBonte's 'excluded list' are "women, racial minorities, the poor and the sick, those with disabilities, children and youth" (2004:117). The ways in which society upholds the powerful at the expense of the powerless receives considerable attention from both Foucault and LaBonte, two scholars who lived and worked in different eras but whose views on social exclusion have much in common.

2.12 Social exclusion: Contextualising meaning

Foucault's observations are regarded as one of the precursors to later discourse about social exclusion. Growing concerns from humanitarians and academics in the latter half of the 20th century saw a more concerted effort by governments to treat exclusion as a serious social matter. Human rights advocates highlighted the need to reform neoliberal policies that risked alienating already marginalised groups and individuals, thereby undermining social cohesion and stability (Kostenko et al. 2009; Silver 2007, 2010). The primary focus became the processes by which vulnerable, minority and marginalised people were excluded and what could be done to create change that produced inclusion in customary standards of social, economic, political and cultural activities (Bailey et al. 2004).

As identified earlier in this chapter, relational approaches to social exclusion emphasise a shift from traditional measurements, such as income deprivation, to a broader evaluation that examines issues associated with the role of institutional structures and processes (Pate 2009; Popay et al. 2008; Saunders 2013; Saunders et al. 2008; Taket et al. 2009). The usefulness of this perspective in developing a framework of social exclusion is its coordinated approach to multidimensional deprivation and its causes. It locates determinants of social exclusion such as disability, substance misuse, health, education and employment, access to goods and services, poverty and marginalisation within existing economic, social, political and institutional forces that affect people's wellbeing (Adam and Potvin 2017; Babajanian and Hagen-Zanker 2012; Mathieson et al. 2008).

Social exclusion: Where theory meets reality

In terms of emerging theoretical paradigms, critical criminology and critical disability studies are dynamic and evolving. While social theory is at the heart of both, in that they focus on challenging traditional understandings of crime and disability, this is accompanied by a social realist perspective that takes into account contextual factors. Critical criminology examines crime by considering the genesis of crime, power relations within society, and the nature of 'justice' according to class, gender, race and status inequalities. Critical disability theorists consider how institutions and societies 'dis-able' people systematically and socially by analysing disability as a cultural, historical, social and political phenomenon (Meekosha and Shuttleworth 2009). In considering both paradigms, a unique theoretical perspective with practical application is offered by Dowse et. al. (2009) and brings together the aligned fields of critical criminology and critical disability studies under the umbrella of 'disabling critical criminology'. Dowse et. al. (2009) argue that impairments such as mental health disorders and cognitive disability directly contribute to social exclusion, which increases vulnerability to entrenchment within the CJS, and that such CJS interactions are in and of themselves, disabling experiences.

It has been a relatively slow process for critical criminology to acknowledge the chasm between theory building and the reality of the actual consequences and governmental realities of crime. However, Braithwaite (1989), using Republican Theory acknowledges that as a discipline, critical criminology might be guided most effectively by recognition of the enduring (and intensifying) processes of social exclusion, and by a closer alliance with progressive social movements. From a practical perspective, this position has much to recommend it, in that it suggests that critical criminology would be enhanced by considering the way in which social action and advocacy strategies might be absorbed into the critical side of the discipline.

In keeping with Braithwaite's call to bring the practical to the theoretical, Schweiger (2013) argues that those who are incarcerated are socially excluded by nearly all measures used in evaluations of social exclusion. He also highlights the involuntary nature of social exclusion – in general, people do not actively seek out 'social exclusion'. Schweiger emphasises 'rights' (cognitive respect) and 'solidarity' (social esteem) as conditions necessary for the development and continuation of self-confidence, self-respect and self-esteem and the way in which their absence violates human dignity (also see Honneth 2007; Kompridis 2004). Schweiger's perception of what it is to be excluded includes the less measurable factors that were evident throughout this research process – disrespect, denigration, compromised self-esteem and an absence of human dignity.

2.12.1 Substance misuse: Cause or consequence of social exclusion?

A further perspective with application to this research is offered by Buchanan (2004). Recognising that substance misuse is pivotal in the lives of the study's participants and a key contributor to their offending, Buchanan's theory of substance misuse and social exclusion makes a valid contribution to the theoretical framework (2004: 389). He argues that:

> Problem drug use is largely a socially constructed phenomenon that has less to do with individual choice or physical dependence, and much more to do with the structural disadvantages, limited opportunities, alternatives, and resources.

Buchanan (2004) maintains that many have endured severe disadvantage *prior* to developing an addiction and substance use often becomes a form of escape.

2.12.2 Mental health and self-harm

Walter Sofronoff's *Queensland Parole System Review* (2016: 8) noted that a "massive proportion" of prisoners suffer from mental illness, which is often implicated in the offence that resulted in their incarceration. He also stated that there is such a lack of appropriate professional staff to work with mentally ill offenders that only a minority are ever seen. The others will eventually be released without these issues having been addressed, despite the fact they are central to offending/reoffending. Self-harm is the most common reason for mental health interventions in correctional settings (Dixon-Gordon et al. 2012). Self-harm occurs regularly in women's prisons where histories of abuse, mental health and substance misuse are more widespread than in the general population (Barton et al. 2014; Butler et al. 2018; Stewart et al. 2018). According to Motz (2016), self-harm is a vessel through which people articulate internal suffering by enabling a feeling of control in a chaotic environment (also see Dixon-Gordon et al. 2012; Gutridge et al. 2019; Kenning et al. 2010; Kottler et al. 2018).

In the absence of adequate and appropriate community resources and support, Australian women's prisons will continue to witness further rises in the number of women with mental health disorders entering the CJS, particularly at its more punitive end, prison (Hislop 2019; Jeffries and Newbold 2016; McCausland et al. 2013). Once there, incarceration itself increases the risk of developing mental illness, as well as exacerbating pre-existing mental health conditions.

2.12.3 Physical health: A casualty of social exclusion

In addition to the question of mental health and social exclusion, a range of scholars draw attention to the links between physical health and social exclusion. These connections arise

from determinants such as low educational attainment, unemployment and homelessness (Graham and Kelly 2004; Guthrie et al. 2013; Popay et al. 2008; van Bergen et al. 2019; Wanless 2004). Groups identified in the context of social exclusion and health include, for example, people with drug and alcohol addictions, those with mental health problems and people with disabilities (O'Donnell et al. 2018). Wilkinson and Marmot (2003) point out that "the greater the length of time that people live in disadvantaged circumstances, the more likely they are to suffer from a range of health problems". Results of the AIHW (2018) survey concerning the health of Australian prisoners highlight the generally poor health of women entering prison and the deleterious effects of prison itself on health and wellbeing.

2.12.4 A question of agency

Cottrell (2001) presents a compelling argument when she highlights the way in which 'agency' is bestowed based on an individual's willingness to subscribe to 'the rules' as laid down by those whose own agency is not in question. She also maintains that 'agency' which is granted to the "deserving poor" (2001: 16) is actually a case of the 'deserving poor' letting go of their own predilections to acquiesce to authorised agendas. This argument has implications for particular groups - Indigenous people, those with mental health and substance abuse disorders, those with cognitive disabilities, those who are homeless, uneducated and/or unemployed - people with little capacity to exercise meaningful agency in their lives (Boardman 2011; Jay et. al. 2018).

2.12.5 A lack of civic engagement

A concept related to agency is that of civic engagement, particularly its absence in the lives of people such as the women involved in this study who face innumerable barriers to inclusion in community life. Cognitive disability, behaviours regarded as antisocial and/or challenging, substance misuse, mental illness, homelessness and criminality are roadblocks to civic engagement and participation (Bazemore and Stinchcomb 2004; Uggen and Manza 2002). Women who are defined in terms of any or all of these characteristics are regularly denied access to the roles that traditionally connect most civilians to conventional society (Uggen and Manza 2002). As Bazemore and Stinchcomb (2004) argue, because personal and civic identity are intertwined with connections to various social institutions, the overt and covert exclusion of certain individuals and groups from civic participation results in their disconnection from community, creating entrenched marginalisation.

2.12.6 Trust and safety - or not

Scholars such as Iliffe and Steed (2000) maintain that women who have suffered trauma undergo a variety of changes, including radical changes to their worldview in terms of trust, safety and feelings of isolation and powerlessness. These potentially manifest as anxiety and depression, self-harm, eating disorders, social distancing, substance use and low self- esteem (also see Jaffe 2016). The erosion of trust and safety often begins in childhood, stemming from physical, emotional and sexual abuse at the hands of family members and other people known to the child. Survivors of such abuse find it difficult to develop and maintain healthy interpersonal relationships because they are unable to trust those around them or to feel safe in any situation (Hall and Hall 2011).

However, it is not only the impact of the lack of trust and safety on the individual lives of the women themselves, it is also the view from 'the other side' that augments social exclusion. Cameron (2005: 311) argues that, "trust is a complex phenomenon and is related to variables within individuals, as well as within families, neighbourhoods, and society as a whole". Notions of 'trust and safety', fundamental to social inclusion, are premised on perceptions of risk, so that people perceived as low in general trust and, therefore a risk to society, tend to be purposely isolated from the community. Signs of social distrust are reflected in constant demands for a higher police presence on the streets, with an expectation that those deemed 'untrustworthy' or 'unsafe' will be removed from the area (Cameron 2005; Travis 2000; Walklate 2001).

2.13 Social exclusion and links with offending

In Australia, links between 'social exclusion' and 'offending' are generally accepted as fact by government bodies, non-government agencies and those operating within state Corrective Services. As Rose (2000: 336) maintains, "exclusion itself is effectively criminalised" when punishment is metred out for offences committed in pursuit of survival, such as stealing. Offending is seen as being "either or both, a symptom and a product of exclusion" (Bowles 2012: 106). Until recently, data pertaining to a person's offending, such as police and CJS data, and that related to other aspects of an offender's life, such as mental health or cognitive disability, were generally kept separate so that offending 'careers' were most often regarded as a compilation of offences that told the story of the person's criminality (Bowles 2012). However, there has been pressure from government authorities and non-government organisations working at the 'coal-face' of the CJS to examine ways to reduce rates of reoffending and to create databases that provide more holistic information about offenders (Bowles 2012).

This has generated an exploration of offending and reoffending in the light of social exclusion (Bowles 2012; Cunliffe and Shepherd 2007; May et al. 2008). In general, studies of those convicted of a crime and sent to prison provide substantial evidence of the various indicators of social exclusion: lack of education, unstable housing, low employment, poor or reduced levels of health, increased incidence of mental illness, reduced levels of personal safety, high prevalence of substance misuse, stigma, and low levels of community and civic engagement (Harper et al. 2005; Hayes et al. 2008; Murray 2007). Not only does this mean that offenders are socially excluded, it is very difficult for them to be socially *included* upon release.

2.14 Australia's response to social exclusion

While Europe and the United Kingdom have a lengthy history of research and policy with respect to social exclusion, Australia has been a more recent addition to social exclusion discourse (e.g., Kostenko et al. 2009; Saunders 2011; Scutella et al. 2009). The latter third of the 20th century saw Australia acknowledge the need for a more inclusive social model. However, it has been only comparatively recently, with the creation of the Social Inclusion Board (in 2008), that the Australian Government seriously considered the impact of social exclusion on disadvantaged groups. Nevertheless, there is no recognition in *The Social Inclusion Agenda* (Australian Government 2009a, 2009b, 2012b) of incarceration as a determinant of social exclusion or its inverse, that social exclusion contributes to incarceration. This is despite stating that "many of the most disadvantaged people in our society are often grappling with multiple disadvantage that puts them at greater risk of being socially excluded" (2012b: 14).

Various authors (e.g., Bigby and Wiesel 2015; Van Asselt et al. 2015; Welsby and Horsfall 2011; Wiesel and Bigby 2016; Wiesel et al. 2013) highlight the fact that people with cognitive disabilities, while being physically 'present', continue to occupy a "marginalised social space in the community, given that they continue to live in *de facto* 'segregated' communities with limited contact with people in the wider community" (Gooding et al. 2017: 14). The 2009 investigation by the National People with Disabilities and Carer Council, *Shut Out: The Experience of People with Disabilities and Their Families in Australia*, reveals a lack of progress in challenging dominant approaches towards disability and the general fallacies shaping the outlooks and actions of not just individual people, but governments. This results in regular experiences of discrimination and exclusion for those with disabilities.

2.15 CJS interactions and pathways to prison

For the women in this study, challenges related to their cognitive disabilities in areas such as education and employment, along with adult victimisation through dysfunctional relationships, have implications in terms of the potential for CJS involvement. Australian and international literature highlight the strong correlation between incarceration and the combination of familial, social, institutional, and policy/legislative factors that reduce life chances (e.g., Armstrong et al. 2005; Baldry et. al. 2016; Baldry et al. 2012; Salisbury and Van Voorhis 2009; Simpson et al. 2018), links that the present research investigates.

Building upon 2.13, 2.14 and 2.15, which presented intersectional factors especially pertinent to this study (e.g. lack of agency, civic engagement, and trust and safety, and compromised physical and mental health), the following discussion brings together situational and institutional factors that inform the life-courses of the women participants. This includes, for example, juvenile justice, as well as associated human services such as the CPS. Additionally, the role of peers, noted in Chapter 1 as influential in terms of the manipulation of cognitively disabled people and the commission of criminal acts, has a significant impact on their interactions with the CJS, particularly with respect to police interventions. As will be discussed, access to justice is problematic from several perspectives, not the least of which is a legal system premised on white, middle/upper class values, complex legal language, and a penal code that is geared more towards retribution than rehabilitation. An overview of the prison experience (2.17) provides a brief summary of several of the key factors associated with the incarceration of cognitively disabled women, which will be further developed in the chapters that follow.

2.15.1 Where the past shapes the future

Offending histories often go back to a person's childhood and adolescent years with time spent in juvenile detention facilities. Cunneen et al. (2016) contend that Australia's juvenile justice systems are consistently occupied by society's most vulnerable children who come from situations of intergenerational disadvantage. As various scholars argue (e.g., Cunneen et al. 2016; Cunneen et al. 2015; Halsey 2008; Loeber et al. 2013), the links between juvenile detention and adult incarceration are well established. Of relevance to this study are the numbers of juvenile detainees with cognitive disabilities. Richards (2011: 4) states that "intellectual disabilities are more common among juveniles under the supervision of the criminal justice system than among adults under the supervision of the criminal justice system" and that "juveniles with an intellectual disability are at significantly higher risk of recidivism

than other juveniles". Cunneen et al. (2016) point to the fact that despite blanket protections supposedly in place for young people with cognitive disabilities, they have thus far had minimal impact on the increasing overrepresentation of cognitively disabled youth caught up in the juvenile justice system (also see Cunneen et al. 2015).

2.15.2 Child Protection Services

Children who enter foster care typically come from families and/or communities that reflect various determinants of social exclusion, for example, unemployment and low income, unstable accommodation, high crime and poor health (Miranti et al. 2018). Once in the system, children generally do not have someone who is unconditionally committed to them, which according to Warren (1997), is one of the crucial factors in the process of social exclusion. Many children experience multiple placements, further contributing to their social exclusion. Relocation is generally accompanied by changes to schools, friends and also their way of living, especially if they are entering a new arrangement in which there are many more foster children placements (Kendrick 2009).

2.15.3 The influence of peers

Cockram (2000) points to the manipulation by peers as a factor contributing to the high rate of offending/reoffending by people with cognitive disabilities. Lindsay et al. (2004) stress that peer group influence is highly significant in the development of offending behaviour by cognitively disabled people. Peer pressure often leads to antisocial behaviour and coercion to commit acts that attract police attention, with the person in question left (sometimes quite literally) 'holding the bag'. Bexkens et al. (2019) highlight the relationship between low cognitive function, risk-taking (such as antisocial behaviour in public spaces) and increased susceptibility to peer influence, whereby the expectation of a reward, such as being included in a friendship group, is the driver for behaviours that may result in police interventions. The risk of being ostracised by peers for non-compliance is often of greater significance than the risks associated with criminal behaviour (Bexkens et al. 2019). A related concern for those with cognitive disabilities, arising from the fear of being victimised by peers, is the potential for that situation to heighten the risk of internalising conditions such as depression and anxiety (Christensen and Baker 2020). While there is broad acknowledgement that these issues exist, there is also the recognition that peer influences act in conjunction with structural elements (e.g., dysfunctional families, poverty and poor education) to create a situation in which peer acceptance is used to mitigate these factors (Emerson and Halpin 2013; Emerson and Hatton 2007; Rowe et al. 2010).

2.15.4 Access to justice

The *Convention on the Rights of Persons with Disabilities* (2007) (CRPD) Article 13 states that people with disabilities must be provided with necessary modifications and adjustments to obtain effective access to justice. Australia became a signatory to the CRPD in 2008, thereby recognising that those with disabilities should have the same rights to legal representation as anyone else and that appropriate initiatives be instigated to ensure the provision of any support necessary to exercise their legal capacity (Australian Law Reform Commission [ALRC] 2013). As McSherry et al. (2017) recognise, for many people with cognitive disabilities this is not always possible (also see Gray et al. 2009; Grunseit et al. 2008). From their first contact with the CJS there are a multitude of barriers that reduce their ability to access justice (National Council on Intellectual Disability [NCID] 2013), including comprehension of the legal processes in which they are involved.

2.15.5 The police: Gatekeepers of the CJS

One of the effects of deinstitutionalisation has been the number of people police are now encountering who have complex needs and associated vulnerabilities (Spivak and Thomas 2013). As such, the police role is not just one of law enforcement but also assessors of mental and/or cognitive disorders and referrals to other services (NCID 2013). Human rights advocates emphasise a moral code (though not a legal one) whereby police issuing a caution need to ensure the person understands what is said to them (Australian Human Rights Commission [AHRC] 2019). Cautions are generally phrased using terminology such as "before you say anything further about this matter, I must warn you that you are not obliged to say anything unless you wish, as anything you do say will be recorded and may later be used in evidence against you. Do you understand that?" (AHRC 2019: Ch. 5). Foregoing the right to silence and answering questions after a caution has been issued is problematic because there is no guarantee that there is a genuine understanding of rights by the apprehended person.

Over and above issues of communication and not understanding either the nature of their offence or their rights, the suggestibility of those with cognitive disabilities and the problem of acquiescence (i.e., answering 'yes' to questions they do not understand) along with unsuitable questioning techniques have also been identified as impediments to just outcomes (Bartels 2011; Jones 2007; Ochoa and Rome 2009; French 2007). As Powell (2002: 44) observes, "the greater the communication and social barriers, the more vulnerable the interviewee is to providing information that is misleading, unreliable and self-incriminating".

Research indicates that although police awareness of cognitive and mental disabilities is expanding in some jurisdictions (Spivak and Thomas 2013), there is a "lack of coordinated and evidence-based frameworks for addressing police responses to those who experience issues related to these impairments" (Baldry and Dowse 2013: 225 Also see Baldry et. al. 2012). Another concern is that even when police recognise the presence of one or more disorders, they frequently have nowhere to take the person as suitable facilities are generally full. Baldry and Dowse (2013) note that the police themselves experience frustration regarding this situation, especially when it occurs on a Friday afternoon with no agency help available until the following week. Police therefore become the designated care managers for people with multiple and complex needs.

2.15.6 Policing and First Peoples

The policing of First Peoples remains a contentious issue. The Royal Commission Into Aboriginal Deaths In Custody (1991) found that policing practices substantively contributed to the high arrest rates of Indigenous people and to the high number of Indigenous deaths in custody. Since that time, awareness and training strategies have been implemented by Australian state and territory police services. Nevertheless, the tension between police and Indigenous communities remains (McCausland et al. 2015; Weatherburn et. al. 2008). In discussing the interface between police and Indigenous people, the ALRC (2018a: 14.13) notes that several issues continue to shape Indigenous/police interactions. These relate to the over-policing of public order offences and the constant monitoring of those on bail or parole, juxtaposed with under-policing of family violence, especially when the victim is an Indigenous woman.

2.15.7 Legal processes: Access or barriers to justice?

The ability of people with cognitive disabilities to effectively use the law to help them, or to participate in legal proceedings, is impacted by a range of factors related not only to the specific circumstances of the person, but also to the complex nature of the law and the legal system (Baldry 2011; Gray et al. 2009). Even if found 'unfit to plead' because of cognitive disability and/or mental illness, they may still face indeterminate confinement in prison or remand centres, which in many cases exceeds the time they would have served if they had been formally sentenced (Arstein-Kerslake et al. 2017; Baldry 2018).

The fact that people with cognitive disabilities are more likely to be refused bail and remanded in custody than those without a disability is also notable (AHRC 2014; Brown and Kelly 2012; Cunneen et al. 2013; Shepherd et al. 2017). As with bail applications, minimal instances of

parole being granted is attributed to a perceived lack of understanding of what attached conditions involve and an assumption that they will breach the orders (Anti-Discrimination Commission Queensland [ADCQ] 2019; Birgden 2016; Gray et al. 2009; QAI 2015). There are also many instances in which people with cognitive disabilities serve their full sentence because they are unable to meet the written requirements of the parole application system (Grunseit et al. 2008). Cognitive disability frequently precludes participation in educational and other programs necessary for the granting of parole, which further denies opportunities for early release (Grunseit et al. 2008).

Gray et al. (2009) provide evidence of cognitively disabled clients who experience difficulties in relating their story to a lawyer. There is a disconnect between 'information given' and 'information received', in part due to legal practitioners who lack understanding, or may have predetermined ideas about working with cognitively impaired people (Gray et al. 2009; Grunseit et al. 2008; Simpson et al. 2001). Grunseit et al. (2008) highlight a range of issues further impacting access to justice. Unstable living arrangements and homelessness mean that documentation is not always received, and so legal problems accumulate prior to incarceration. For some, going to court is avoided because of previous negative outcomes, or because they have no support to navigate the process. Legal procedures that rely on the written and spoken word using language that is mostly complex serve to exclude those with impaired cognitive function.

In contemplating the contributions of noted scholars, for example Baldry (2009, 2010, 2011, 2014, 2017, 2018), Cunneen et. al. (2013; 2015; 2017), Dowse et. al. (2009), and McCausland et. al. (2013; 2015; 2017), among others,

2.16 The experience of prison

In a climate of retribution, politicians rarely speak out in favour of fewer and shorter custodial sentences (Player 2014; Cunneen et al. 2013). This particularly impacts women, especially those with cognitive disabilities whose offending is generally at the lower end of offence seriousness (Jeffries and Newbold 2016). Claims of gender neutrality (Hannah-Moffat 2006, 2009) with respect to practices of incarceration fail to consider the context of women's offending and the experiences that contribute to it. The focus is invariably on the individual's deficits rather than the political and structural issues that define their life chances (Hannah-Moffat 2010). Essentially, the emphasis becomes one of reducing 'criminal risk' as opposed to reducing 'social harm' (Player 2014; Carlen and Worrall 2004).

Cunneen et al. (2013) point to the deleterious effects of using prisons as repositories for cognitively and mentally impaired people. Arguments along the lines of the perceived benefits of time spent in prison, for example, three meals a day and some form of health care, shift the focus away from the main role of prisons - containment and security. Even if there have been worthwhile interventions while in prison, for example, those related to addiction or mental illness, there is no certainty these will be maintained out in the community. In fact, the only assurances arising from imprisonment are the creation of links to criminality and basing 'survival skills' upon those learned in the prison environment (Cunneen et al. 2016; Haney 2002).

2.17 Conclusion

Chapter 2 examined the literature around a number of separate but interrelated areas that guide this dissertation's response to the research questions. This chapter provided an explanation of the terminology used throughout the study, including 'cognitive disability', 'comorbidity', 'dual diagnosis' and 'complex needs'. Cognitive disability, along with histories of trauma and coexisting criminogenic factors (such as homelessness, education deficits, inappropriate peer networks, family dysfunction, domestic violence and substance misuse) contribute to offending and incarceration.

As a precursor to an examination of social exclusion, the topic of deinstitutionalisation was considered. Deinstitutionalisation involved the closure of institutions for the cognitively disabled and mentally ill in the wake of inclusionary policies. In Australia, however, these closures triggered a rise in homelessness and incarceration, due in part to insufficient resources allocated to facilitate a successful transition to community living.

In turning to the notion of stigma, Goffman's (1963) theoretical perspectives underpinned a discussion of intersectional stigma and its relationship to social exclusion. Stigmatised identities, associated with behaviour such as substance abuse and criminality, as well as stigma based on class, gender, disability, Indigeneity, homelessness, and various combinations of these, are particularly relevant to the women in this study. These perceptions continue to inform public and institutional assessments of, and reactions to, women with cognitive disabilities who end up in the CJS.

Goffman's (1961) perspective on 'total institutions' was a conduit to Foucault's (1977) assessment of the exclusionary nature of prisons. Foucault's interest in prisons arose not only from questions about the way in which prison reinforce power through the creation of 'docile

bodies', but also the idea that prisons provide a window through which to view society itself. The application of Foucault's work to the area of disability provided a lens through which to examine the philosophies of contemporary scholars working in the related fields of social exclusion, cognitive disability, complex needs, and incarceration.

This chapter also presented the challenges for women with cognitive disability in accessing justice. From police interventions through to the way in which legal representatives manage impaired cognition, the difficulties associated with comprehending complex language and CJS processes was also considered. Pivotal to any discussion of women's incarceration is the role of historic and ongoing trauma, acknowledging that prison itself contributes to pre-existing trauma. The incongruity of the prison as simultaneously a place of punishment and one of refuge brought to light the lack of options for women to be supported within the community.

What is apparent from a review of the diversified literature, is the notion that from a theoretical perspective, there have been significant advances in acknowledging that a linear approach to both theory and practice is of limited value. As this chapter noted, innovative theoretical frameworks such as that developed by Dowse et. al. (2009) in which critical criminology and critical disability studies converge, are significant because they take account of life-courses impacted by cognitive disability and mental health disorders and the way in which these factors increase susceptibility to contact with the CJS and by extension, to social exclusion. However, as they and various other scholars note, while the topic of social exclusion has made its way on to political agendas within Australia, there is a distinct lack of progress in addressing inequality. This is evidenced by unequal access to health and education, job opportunities and civic participation. 'Inclusion' is something that is conditionally conferred upon people such as the women who participated in this study and is dependent on their compliance with rules and expectations laid down by the dominant society.

The key message moving forward is the relationship between social exclusion and cognitively disabled women who are incarcerated. While there is a clear dynamic between incarceration and social exclusion, this chapter highlighted the additional layers of complexity associated with comorbid conditions such as cognitive disability, mental health and substance abuse disorders, and social, structural and institutional forces that operate to ensure sustained social exclusion.

Chapter 3: Research Design

3.1 Introduction

Chapter 3 discusses the study's research design and methods adopted to address the research questions. This study utilised semi-structured interviews conducted with incarcerated women with cognitive disabilities in three Australian states. In addition, interviews with prison practitioners yielded essential information about each of the women. This chapter provides information about the research populations, sampling and data collection. Thematic coding was used to generate and inform the study's findings. An explanation of the challenges and limitations of this research project concludes the chapter.

3.2 Study aims and objectives

As stated in Chapter 1, the purpose of this study was to examine the links between social exclusion, cognitive disability and incarceration, and how they intersect to create and perpetuate a cycle of disadvantage and offending/reoffending. The study was guided by three key questions:

1) How does social exclusion contribute to the trajectory of women with cognitive disabilities into prison?
2) How does social exclusion manifest in prison for women with cognitive disabilities?
3) How do prisons respond to the needs of women with cognitive disabilities?

A core objective of this research was to advance the literature in an under-researched area of scholarship. To do this, the current study investigated social exclusion from the perspective of women who experience marginalisation because of intersectional factors, for example, cognitive disability, mental illness, substance misuse and incarceration. The study also explored these issues from the perspective of prison practitioners, fundamental to addressing the question of prison responses to women with cognitive disabilities.

In considering the significant number of factors linked to social exclusion, along with the nature of the prison participants (that is, women with cognitive disabilities), a qualitative approach was deemed the most appropriate, using individual narratives to investigate the social, structural, cultural and economic circumstances contributing to a life story. Semi-structured interviews using appreciative inquiry (Liebling 1999; Liebling et al. 2001) and strengths-based language (Wormer 1999) support such an approach. Appreciative inquiry seeks to substitute

problem-focused language (upon which much prison research is based) and instead frames questions to encourage, if not a completely optimistic response, at least one that takes the time to consider the positive aspects of the person's life. Liebling et al. (1999) point out that this approach is not intended to dismiss the hardship and challenges of incarceration; rather, it aims to encourage both practitioners and prisoners to consider an alternative view, one that acknowledges personal strengths and accomplishments. Appreciative inquiry draws upon an interviewee's memories and imagination, in terms of 'what was' and 'what could be'. Appreciative inquiry and a strengths-based approach share a natural affiliation, and together they comprise a strategy that enhances narrative research, particularly in the context of the prison, which is often a pessimistic environment.

3.2.1 The utility of narrative inquiry

Creating a climate conducive to storytelling was an important first step in facilitating a natural progression from one topic of conversation to another (Riessman 2008). This was essential for the research, particularly given that the participants were being asked to engage with someone unfamiliar and furthermore, to talk about some very personal issues. In light of the aims and objectives of the research, and in view of the women participants, narrative inquiry was the most appropriate approach. At the heart of this approach is "the ways humans experience the world" (Connelly and Clandinin 1990: 2). Clandinin and Connelly (2000: 80) employ the phrase "experiencing the experience", referring to it as the baseline 'why' for social science inquiry. The significance of narrative research is that the focus remains on the individual and how they perceive and understand their life experiences (Andrews 2000; Cresswell, 2007; Cresswell et al. 2007; Lindemann-Nelson 2001). Most narrative research projects are based on interviews of one kind or another – in this case, semi-structured interviews. However, this research was more akin to two participants in conversation.

3.2.2 Women who have a cognitive disability speaking for themselves

An argument offered by Cunneen (2011: 169) reinforced the reasons for adopting a narrative approach as the most effective for this research project. Cunneen stated that "criminology as a discipline is dominated by narrow positivist assumptions, by an over-reliance on administrative 'data' and their endless statistical manipulations" which detracts from the meaning that individuals attribute to their understanding of the situations in which they are placed. According to Cunneen (2011), there is an imperative to understand the broader patterns of social structure that contribute to the ways in which those we are researching experience life events. Along similar lines, Popay et al. (1998) introduce the concept of 'lay knowledge', which they maintain

"is rooted in the places that people spend their lives and has theoretical significance for our understanding of the causes of inequalities" (1998: 639). Lay knowledge emanating from the use of narrative provides an alternative view on the relationship between individuals and the environments in which they live. As Popay et al. (1998: 639) argue, approaches to social exclusion "need to look not just at the statistical associations between significant events in people's lives as defined by researchers, but at the meanings people give to the relationship between these events – how they translate events into meaningful episodes". The women's lived reality also provided expert knowledge, insofar as they were the ones who experienced social, systemic and institutional exclusion. The authenticity of this study was augmented by their contributions and that of the prison practitioners. It is their narratives that contribute to filling the gap in the literature identified in Chapters 1 and 2.

Over and above the women's situation of incarceration, people with cognitive disabilities have historically not been asked about their thoughts, feelings, or experiences. This silence has promoted and maintained the view that those with cognitive disabilities are not competent, reliable or trustworthy research participants (Welsby and Horsfall 2011). As such, most research is about them presented from professional and practitioner perspectives. While this trend has seen some modification more recently (e.g., Susinos 2007; McVilly et al. 2006), past praxes often mean that those with a cognitive disability are not considered full citizens in their own lives. Of relevance to this study is the lack of representation of people with disabilities in social exclusion research (Susinos 2007). As noted by Brown (2001), the validity of research in the disability domain is enhanced by including the voices of those with lived experience.

3.2.3 Populations

This study involved semi-structured interviews in Australian women's prisons with two separate populations: (1) women prisoners with cognitive disabilities; and (2) prison practitioners. Each will be discussed in turn.

3.2.3.1 Women prisoners with cognitive disabilities

The primary focus of the research was incarcerated women with cognitive disabilities in Australian women's prisons. For the purposes of this study, the presence of a cognitive disability was *identified by prison psychologists prior to the commencement of data collection.* As discussed in Chapter 2, cognitive disabilities of specific concern to this study included ID, ABI and FASD. Testing for cognitive disability was inconsistent across jurisdictions, with a mixture of IQ testing, Hayes Ability Screening Index (HASI), and responses to risk/needs assessment questions at the time of prison intake. In some cases, cognitive disability had been

diagnosed prior to incarceration, mostly through doctors, disability services and schools. Psychologists and counsellors also informally assessed adaptive and living skills, for example, personal hygiene, cleaning of cell/unit, susceptibility to coercion and the ability to interact appropriately with staff and other prisoners.

3.2.3.2 Prison practitioners

Prison practitioners who worked directly with the women in a professional capacity were asked to participate in the study. This included psychologists, counsellors, Offender Development Managers (ODMs) and Aboriginal Liaison Officers (ALOs). To meet the criteria for inclusion, practitioner roles were defined by the following:

1) prison psychologists who (a) directed the screening of women upon prison entry to ascertain cognitive disabilities or mental health disorders; (b) facilitate individual therapy sessions with the women; and (c) manage reviews of therapeutic interventions
2) prison counsellors (often social workers) who conduct individual counselling and supervise group programs
3) ODMs who oversee education, training and program participation
4) ALOs who provide assistance to Indigenous prisoners.

3.2.3.3 Sampling

Applications to conduct this research were made to the Department of Corrective Services in every Australian state and territory. Queensland, South Australian and Tasmanian Corrective Services approved the research. This response enabled data collection in a range of women's prisons in diverse jurisdictions. Other jurisdictions cited an inability to facilitate research because of prison practitioner caseloads.

Corrective Services in each participating jurisdiction contacted the women's prisons to seek their cooperation. The study received the support of each prison. As a next step, a practitioner from the individual prisons was approached by state Corrective Services to be the point of contact to discuss potential prisoner participants and to organise data collection timeframes. In Queensland and Tasmania, the contact people were prison psychologists, and in South Australia, the manager of offender development. In addition to approaching potential prisoner participants, the designated practitioner contacted other professional prison personnel working with the women to gauge their willingness to be included in this study.

The researcher then contacted each of the women's prisons in the three jurisdictions, a total of five prisons. Numinbah Correctional Centre in Queensland, a low-security facility for women, was willing to participate, but did not have any women prisoners fitting the selection criteria during the data collection timeframe. As such, the four participating prisons were:

- Adelaide Women's Prison (AWP), Adelaide, South Australia
- Mary Hutchinson Women's Prison (MHWP), Hobart, Tasmania
- Townsville Women's Correctional Centre (TWCC), Townsville, Queensland
- Brisbane Women's Correctional Centre (BWCC), Brisbane, Queensland.

3.2.3.4 Prisoner participants

Prison practitioners approached 25 possible participants across women's prisons in three Australian states. Other potential interviewees were not asked because of the risk of harm, such as stress and anxiety. Of those women meeting the selection criteria for inclusion in the research, only two declined to participate. The final prisoner sample for this study was n = 23. As noted by Dworkin (2012), qualitative research saturation is achieved at a sample size of 25, which highlights the positive implications for this study's response rate.

3.2.3.5 Prison practitioners

The designated prison practitioners approached a total of 12 practitioners across the four participating prisons who met the inclusion criteria. All 12 practitioners agreed to participate. However, unforeseen circumstances on the day of interview saw the withdrawal of two practitioners. As such, the final prison practitioner sample for this study was n = 10, comprising two psychologists from MHWP; the ODM and ALO from AWP; a psychologist, the ODM and ALO from TWCC; and a psychologist, the ALO and a counsellor from BWCC.

3.3 Data collection

Interviews with prisoners took place in a variety of prison locations, depending on the women's security rating. For women rated as minimum security, interviews were mostly conducted in offices. Interviews with women with a maximum-security rating, housed in Detention and Safe Units, took place in offices contained within those units. Two maximum-security interviews took place in a small, securely fenced outdoor areas adjacent to the cells, with the participant on one side of the fence and the researcher on the other. Interviews generally went for an hour, with several lasting an hour and a half.

While the aim of narrative interviewing is to generate detailed accounts rather than brief answers (Riessman 2008), the nature of the prisoner population had to be carefully considered. The semi-structured interview schedule for the women consisted of a substantial 'pool' of questions (see Appendix 1) designed to cater to several different scenarios. First, questions phrased in a vague or open-ended way were avoided. Such questions often present challenges to those with compromised cognitive skills, in terms of interpretation and response. The phrasing of questions was crucial in that they needed to be easily understood while simultaneously drawing out a range of information. For example, a simple question such as "how did you get on with your family when you were younger?" elicited a wide variety of responses, touching on issues of family violence, bullying, parental absence or neglect, and interactions within blended families. Essentially, straightforward questions invited associations and meanings which brought together several different stories. Secondly, the interview schedule had to include sufficient questions to be able to move from one to another if only minimal responses were given, or if an interviewee did not want to answer a particular question. Having a broad range of questions was a safety net to allow the interview to progress. While the interview schedule consisted of many questions, not all interviewees answered every question. Instead, the questions facilitated a conversation. Third, the method of question delivery was paramount. Asking questions in rapid-fire succession would have been counterproductive. As with most successful narrative inquiries, a conversational style was essential to creating an environment that was as comfortable as possible, especially given that these conversations were taking place in an uninviting setting.

Interviews with prison personnel lasted one to two hours and were held in the practitioners' offices. Prison staff provided information related to crimes committed, arrest, charge and conviction records, significant life events, the women's children, foster care status (for both the women and their children), mental health disorders, substance misuse, physical health and medication, program participation, prison employment, prison accommodation and security status, visitation and phone calls, and familial incarceration. These interviews were important, not only for the administrative data they provided, but also for supplying information that some of the women may not have talked about, including issues ranging from arrest and conviction records to more personal details such as mental health and substance misuse. Questions for both cohorts were designed to shed light on the social exclusion of the participants specifically and incarcerated women with cognitive disabilities generally.

3.4 Measures and analytic strategy

Chapter 2 identified the various scholars who view social exclusion as something more than poverty and income deprivation, recognising the social and structural factors that are central to generating and maintaining social exclusion (e.g., Levitas et al. 2007; Saunders 2011; 2013). The flexibility of a relational approach was useful to the current study, which required a more inventive range of social exclusion domains that could be investigated in the offender/prison context. An original framework created by Lafferty et al. (2016), in which social exclusion/inclusion is broken down into six domains, was useful for this purpose. They propose the following as a suitable approach to investigating social exclusion in the prison setting.

1) Informal networks, including family and friends
2) Formal networks, including employment, education, program participation, CPS and CJS
3) Trust and safety, including family and peers, CJS agents, CPS, and other prisoners and staff
4) Health and wellbeing, including mental and physical health, substance use and access to health professionals in/out of prison
5) Agency, including program participation
6) Civic engagement, including community involvement, voluntary work, prison employment and research participation

For the purpose of this study, Lafferty et al.'s model was modified to include informal networks, formal networks, trust and safety, and health and wellbeing *outside* the prison. As such, the model used for this dissertation has 12 domains—the six above-listed domains for inside *and* outside prison. To explore these domains, two sets of questions were created, one for prisoners and the other for practitioners (see Appendix 2). The separation of 'inside' and 'outside' is warranted, given the research questions and objectives of the study. I acknowledge that these domains do not exist in isolation are, in reality, interconnected. However, examination of these domains makes it possible to draw out both the lived experiences of the study's women participants, as well as the systemic and structural factors impacting upon them.

The six domains of social exclusion employed by this study comprise a series of indicators, with questions designed to examine each one. These indicators were derived from the wider social exclusion literature, as discussed in Chapter 2. Indicators were selected on the basis of their relevance to the study's prison population. While individual indicators are important, so too are the domains as they provide a structure in which to house the selected indicators, helpful

for framing the interview questions. However, it is essential to keep in mind that neither the domains nor the indicators exist in isolation, and it is the interrelated nature of the domains and their indicators that guided the development of this framework and provided the focus for questions directed to both study populations.

The exploration of these social exclusion domains and their specific indicators was underpinned by the presence of cognitive disability, a major factor when considering *how* and *why* the lived experiences of the women in this study are different to most other incarcerated women. It is important to contextualise the women's narratives in the light of the vulnerabilities that accompany cognitive disability. Lack of capacity to make informed choices, to escape abusive situations, to regulate emotions, to exercise caution in volatile circumstances, and an overall paucity of essential life skills, leaves them open to maltreatment, suggestibility and coercion, and imitating the inappropriate behaviours of others.

3.5 Domains 1-6 Outside the prison

Responses to questions about social exclusion indicators *outside prison* contained within Domains 1-6, were used to address Research Question 1:

> How does social exclusion contribute to the trajectory of women with cognitive disabilities into prison?

Each indicator was crucial to building a profile of the women's lives prior to incarceration and for determining the way in which the connections between them heightened both the risk and impact of social exclusion outside of the prison environment.

3.5.1 Domain 1: Informal networks outside prison

In measuring informal networks outside prison, questions were designed for practitioners and prisoners that would provide information related to a number of key social exclusion indicators. These indicators are depicted in Table 1, which also provides a sample of the questions asked.

Table 1: Informal networks outside prison

Indicator	Examples of women's questions	Examples of practitioner questions
Family dysfunction	Where did you live when you were little? Who lived with you?	What were the family circumstances of (name)?

Indicator	Examples of women's questions	Examples of practitioner questions
Socioeconomic circumstances	Where did you live? Can you remember what your house was like?	Have you any information about the location of where (name) lived when she was younger?
Community (Indigenous)	Do you still have contact with your community?	Do you have knowledge of the education/employment situation in the family? Where is (name's) community? What can you tell me about it?
Child sexual abuse	How did you get on with your family?	To your knowledge, was (name) sexually and/or physically abused by biological/non-biological parents?
Family violence	Do you have a partner? How was your relationship with your partner before you came here?	Has family violence been an issue that (name) has talked about?
Homelessness	Where are some of the other places you have lived?	What are you able to tell me about the circumstances that resulted in homelessness?
Grief and loss	Has anything ever made you really sad?	To what extent has (name) been affected by loss?
Friends	Do you have friends who are special?	Has (name) ever talked about friends, particularly having a 'best friend'?
Bullying	Was anyone ever mean to you?	Are you aware of any peer associations that may have had either a positive or negative impact?
Respect	Do you think that the people you know respect one another?	Does (name) ever talk about being 'respected' or 'disrespected'?

3.5.2 Domain 2: Formal networks outside prison

In measuring formal networks outside of prison, questions were created around social exclusion indicators such as education and employment, along with involvement with institutions such as CPS and the CJS (see Table 2). Moving from an investigation of Domain 1 to that of Domain 2 highlights the interface between indicators, as well as the ripple effect of social exclusion. For example, informal networks such as family and peers may influence the progression to formal interactions with the CJS.

Table 2: Formal networks outside prison

Indicator	Examples of women's questions	Examples of practitioner questions
Type of school	What things did you like/dislike about school?	Can you provide any details about the nature of (name's) education? Did they attend a special school?
Exit from school	How long were you at school?	
Work history	What did you do when you left school?	Are you aware of any job they may have had?
Foster homes	Did you ever live in a foster home?	Do you have information about the circumstances leading to (name's) transition to state care or the nature of the placement?
Unstable housing	Do you feel able to talk about why you think you lived in a foster home?	How many placements did (name) have? Was there ever a time they moved back home?
Dysfunctional families	Did your brothers and sisters also live in foster care? In the same house as you?	Do you know if (name's) siblings were also taken by CPS? Were they in the same placement?
Intergenerational foster care	Do you have children? Who cares for your children?	What is the situation with respect to the removal of (name's) children by CPS?
Indigenous communities	Can you tell me about how the people in your community get along with each other?	What can you tell me about the practice of forced child removal?
Policing	How do get along with the police?	What have (name's) interactions with police generally been like?
Family incarceration	Has anyone from your family ever been to prison?	Is there a history of family or partner incarceration?
Victim/offender nexus	Are the police fair to both you and your partner?	Has (name) been named as both a victim and offender in domestic violence citations?
Court processes	What was it like for you when you went to court? Did someone help you?	What is your view of court processes for cognitively disabled women?
Peers	Did any of your friends ever ask you to do something bad?	What do you know about the involvement of peers in (name's) juvenile offending?

Indicator	Examples of women's questions	Examples of practitioner questions
Onset of criminality	Have you ever been to 'juvy' (juvenile detention)?	Has (name) ever spent time in a juvenile facility? Why?

3.5.3 Domain 3: Trust and safety outside prison

To ascertain perceptions of trust and safety outside the prison setting, questions focused on family and peers, but with a different emphasis to those asked when investigating Domains 1 and 2 (see Table 3). Despite a reference to similar indicators, the altered phrasing of questions was a useful strategy to invite further reflections from both the women and practitioners, which provided additional data rather than a repetition of information.

Table 3: Trust and safety outside prison

Indicator	Examples of women's questions	Examples of practitioner questions
Family and domestic violence	Before you came to prison, were there times that you didn't feel safe?	Were (name's? family or domestic circumstances the main reason she didn't feel safe?
(Indigenous) Community breakdown	Do the Elders in your community help you to feel safe?	What is the situation re (name's) community, particularly the role of Elders?
Child sexual abuse	Which adults in your life did you fell you could trust? Was there anyone who made you feel unsafe?	Were there any interventions during the time that (name) was being abused?
Adult abuse	Did you know where to get help if you felt unsafe or frightened?	Has (name) ever spoken about being abused as an adult? Do you know of anyone they might have trusted?
Homelessness	When you didn't have a place to stay, where were the safest places to try and sleep?	When (name) was homeless, were there any interventions initiated to help her?
Trust in friends	Did you have friends who stuck up for you? Were there times when you didn't feel safe with your friends?	Were peer group associations responsible in any way for (name's) interactions with the CJS?
Children	What things do you think are good ideas for keeping children safe?	How long was (name) in state care? Was there any parental or family contact during this time?

Indicator	Examples of women's questions	Examples of practitioner questions
Juvenile detention	When you were in juvy, did you feel safe? Did you trust the people in charge?	
Police	Do you trust the police? Were there times that the police helped you?	Considering perceptions of trust and safety, do you think (name) had any kind of trusting relationship with anyone who was part of the CJS processes? (e.g. her lawyer?)
Lawyers	Did you trust your lawyer?	
Judges	When you were in court did you trust the judge? Do you think the court people showed you respect?	
Reciprocity of trust	When you are out in the community, do you feel that other people trust you?	

3.5.4 Domain 4: Health and wellbeing outside prison

Questions regarding health and wellbeing provided information about the women's perceptions of their state of health when they lived in the community, including physical and mental health (see Table 4). As noted in Chapter 2, there are close connections between health and social exclusion. Several of the determinants of health, such as substance abuse, poverty, low education levels and unemployment, lack of access to healthcare, and disability, are closely mirrored by the determinants of social exclusion, highlighted by responses to Domain 4 questions.

Table 4: Health and wellbeing outside prison

Indicator	Examples of women's questions	Examples of practitioner questions
Type of substance(s)	Did you ever try drugs or alcohol?	What is (name's) substance use history?
Age that substance use began	How old do you think you were when you first tried these things?	When did she begin using?
Familial substance use	Did anyone in your family use drugs or alcohol?	Is there a history of substance misuse in (name's) family?
Impact of substances	Do you feel better or worse when you use (drugs/alcohol)?	What impact has prolonged substance use had on (name's) mental and physical health?

Indicator	Examples of women's questions	Examples of practitioner questions
Mental health disorders	Do you suffer from depression or anxiety?	Did(name) enter prison with a pre-existing mental health condition? What, if any, interventions were initiated prior to prison to address her mental health and substance misuse disorders?
Histories of abuse, Loss of children to CPS, Family deaths/suicide	What things make you feel sad?	What do you believe have been the key contributors to (name's) mental health issues?
Separation from Indigenous community	How do you feel when you are away from your community?	Did (name) self-harm prior to being incarcerated?
Self-esteem	What things make you feel good about yourself?	
Childhood health	Were you ever sick when you were little? Did you and your family have a regular doctor? Did you used to visit the Indigenous health clinic?	Do you have any historical information regarding (name's) childhood physical health?
Smoking	Do you feel that you were healthy before you came to prison? Were you a smoker?	Was (name) a smoker? Has this had any ongoing health ramifications?
Diet and exercise	What foods do you like to eat? Is exercise important to you?	Was (name) over/underweight prior to their incarceration?
Chronic conditions	Did you and your family have a family doctor? Were you receiving treatment for any illnesses before you came to prison?	Do you know of any physical conditions that (name) had prior to prison? Was she receiving treatment for these?
Homelessness	When you didn't have a house to live in, how was your health?	

3.5.5 Domain 5: Agency outside prison

Unlike the previous domains, information pertaining to pre-prison agency was relatively sparse. However, the inclusion of this domain was important for exactly that reason in that it illustrates how little control the majority of the study's participants have had over their own lives and the absence of opportunities for making self-determining decisions. Questions were asked about

their plans for post-prison life, possible employment and reconnecting with family and friends to generate conversations about future possibilities (see Table 5).

Table 5: Agency outside prison

Indicator	Examples of women's questions	Examples of practitioner questions
Work	What sort of job do you think you'd like to do when you leave prison?	Do you envisage that (name) will be able to work once she leaves prison? What do you see as the barriers to this?
Job training	Would you be happy to do job training?	What would be needed to facilitate her work opportunities?
Substance misuse	Do you think you will do a program when you leave prison to keep on top of drugs/alcohol?	Are there any accessible and suitable programs in the community that you are aware of to help with substance misuse, parenting, further education, or job training?
Parenting	Would you like to do a parenting program at your community centre?	
Literacy and numeracy	Do you think you might do some more programs like maths or reading?	
Living arrangements	Did you ever choose to leave a relationship that was violent? Where are you going to live when you leave prison?	Do you have an idea of where (name) will most likely live when she leaves prison?
Family and peers	Who do you think you might catch up with when you leave here?	Will there be any restrictions on which family/peers (name) is allowed to socialise with when she leaves prison?
Self-care	What things will you do to make sure you stay fit and healthy?	
Personal safety	What do you need to do to keep yourself safe?	In terms of life skills, what do you consider to be the priorities for (name) remaining safe and well?

3.5.6 Domain 6: Civic engagement outside prison

Civic engagement outside the prison setting was difficult to ascertain, with limited information provided. As with agency, this is significant in terms of illustrating the women's lack of inclusion in the community. This domain is an important consideration, given that engagement in the community is both a major resource and a major challenge for these women (Bazemore

and Boba 2012; Bazemore and Stinchcomb 2004). There are a range of barriers they must face to achieve productive citizenship; barriers generated by cognitive disability, challenging behaviours, mental health and substance abuse disorders. Once out of prison, a criminal conviction also contributes to lack of civic engagement. However, as noted by Boardman (2011), civic engagement and community participation has significant potential to generate inclusivity.

Table 6 indicates the way in which civic engagement was framed via questions relating to the women's perceptions of jobs they had done, including volunteer work, participation in community-based initiatives and carer roles beyond those associated with their children.

Table 6: Civic engagement outside prison

Indicator	Examples of women's questions	Examples of practitioner questions
Community-based programs	Did you join in with any activities in your area that helped to make the community better, such as tree planting or community clean-ups?	Are you aware of any community activities in which (name) participated?
Care of family/friends	Have there been times when you have had to care for family members or friends?	Has (name) ever been in a primary carer role other than her children?
Sport and recreation	Were there activities you enjoyed doing outside of school? Did you play sport?	Has (name) ever talked to you about hobbies or activities she might have done prior to incarceration?

3.6 Domains 7-12: Inside the prison

The study also investigated the domains from an inside prison perspective. Responses to questions about social exclusion indicators *inside prison* contained within Domains 7-12 were used to address Research Questions 2 and 3:

> Research Question 2: How does social exclusion manifest in prison for women with cognitive disabilities?
>
> Research Question 3: How do prisons respond to the needs of women with cognitive disabilities?

3.6.1 Domain 7: Informal networks inside prison

Table 7 provides an overview of the indicators and associated questions developed to investigate the women's informal networks inside prison. Factors such as prison visitation and

connections with children and family has considerable influence on social exclusion/inclusion. This applies not only to the experience of incarceration, but also post-prison life, when these relationships can mark the difference between successful and less successful reintegration. Coercion and bullying, sometimes an outcome of vulnerability associated with cognitive disability and recognised as a damaging component of the women's lives outside prison, is equally detrimental in the confines of the prison environment.

Table 7: Informal networks inside prison

Indicator	Examples of women's questions	Examples of practitioner questions
Family visits	Do you have visitors? How often do you have visitors?	Does (name) receive any family visits? How do these visits normally go?
Other communication	Do you receive any letters or cards? Do you talk on the phone?	Does she receive any letters or cards? Do her family support her financially?
Contact with children	Do your children send letters or cards? Do you talk on the phone?	Does (name's) children visit? Does she talk to them on the phone? What is the nature of their relationship with their children since she has been incarcerated?
Abuse and coercion	Has anyone tried to steal from you?	Is (name) easily coerced?
Friends and acquaintances	Are there other women you get along with?	Has (name) developed any positive peer relationships since being here?
Bullying	Has anyone been unkind?	Has (name) been a victim of bullying?

3.6.2 Domain 8: Formal networks inside prison

Questions pertaining to formal networks inside the prison investigated matters such as the processes associated with prison reception and induction. Table 8 provides examples of the questions directed to the women and prison practitioners. An exploration of the indicators in this domain was crucial in considering social exclusion in the prison context from the perspective of the women's interactions with those in positions of authority. This domain speaks to notions of power and control, as well as the vulnerability of women in an environment that, for the most part, makes few concessions to the impact of living with a cognitive disability.

Table 8: Formal networks inside prison

Indicator	Examples of women's questions	Examples of practitioner questions
Prison reception	What was prison reception and induction like for you?	What sort of testing or assessment was carried out when (name) came to prison?
Strip searches		Can you comment on strip searches?
Remand, Court from prison	Do you know if you have a court date yet?	How does (name) cope with video link court appearances?
Prison staff	How do you get along with the staff here?	How does (name) get along with prison staff?
Therapeutics	What sorts of things has (psychologist) helped you with?	What issues are you working on with (name)?
Children in state care	Who is looking after your children?	What is the likelihood of (name) regaining custody of her children post-prison?
Access to children	Are you able to see your children?	Do the children know that (name) is in prison? Do the children visit?
Numeracy and literacy	Have you done any maths or spelling programs since you've been here?	Has (name) participated in any programs? Did she receive additional help with this?
Program participation	Have you done any other programs?	Has (name) participated in any criminogenic or therapeutic programs?
Job training	Have you done any courses that might help you with getting a job when you leave here?	Has(name) done any vocational training?
Prison employment	Do you have a job here?	How does (name) cope with her job?

3.6.3 Domain 9: Trust and safety inside prison

To examine this domain, questions about trust and safety in the prison setting were created to provide information about perceptions of safe people and safe spaces (see Table 9). In the context of the prison, safe spaces generally referred to accommodation in mainstream (minimum security) areas, or detention/safe units (solitary confinement). Feelings of trust and safety are an accepted, yet only occasionally acknowledged, component of social inclusion, where reciprocal trust between those who are socially included creates a general feeling of

safety. In the prison setting, the significance of trust and safety is heightened because of issues such as suspicion of other prisoners and correctional staff and bullying and coercion in an environment with little scope for respite. The feelings associated with the absence of trust and safety in the prison setting are amplified by the lack of personal autonomy that accompanies incarceration.

Table 9: Trust and safety inside prison

Indicator	Examples of women's questions	Examples of practitioner questions
Links to Elders	Do the Elders visit you? Do you think their visits are helpful?	How much interaction has (name) had with the visiting Elders?
Grief and loss	Do you talk to any of the other women about things that have made you sad?	How has (name?) coped with her past history since she has been here? Do you feel that prison has added to this, or have there been opportunities to help her? Do you feel that you have gained her trust?
Abuse	Do you know where to get help if you feel unsafe or frightened?	Are you aware of any abuse that has occurred since (name) has been in prison?
Trust in other women	Are there other women you can trust?	
Bullying	Is bullying a problem in the prison?	Has (name) been bullied or coerced since coming to prison? Does she report it?
Coercion	Has anyone made you give them money or things that you have bought from the canteen?	Has the prison addressed issues of coercion?
Respect	Do you think people respect one another?	What do you believe to be (name's) understanding of 'respect'?
Prison staff	Do you trust most of the prison staff?	How does (name) get along with prison staff, especially custodial officers?
The prison setting	Do you feel safe in the prison?	Has (name) mentioned any prison areas in which she feels unsafe? How does she cope with accommodation in the detention unit?

3.6.4 Domain 10: Health and wellbeing inside prison

Chapter 2 drew attention to the AIHW's (2018) report, *The Health of Australia's Prisoners*, which portrayed the overall poor mental and physical health of incarcerated women. However, for some women, prison represents an opportunity to access healthcare that may have been unavailable to them in the community. Questions were grouped around the central concerns of substance misuse, mental health and physical health (see Table 10). This domain was a pivotal inclusion, particularly considering the prison context in which healthcare takes place, and the absence of agency in deciding when, or even if, the help of a healthcare professional can be obtained, what treatment options are available and how treatment will be administered.

Table 10: Health and wellbeing inside prison

Indicator	Examples of women's questions	Examples of practitioner questions
Type of substance(s)	Do you think coming to prison has helped you to stop using (drugs/alcohol)?	What were the main substances (name) used prior to coming to prison?
Timeline of use	Can you remember when you started using (drugs/alcohol)?	How old was (name) when she started using?
Impact of substances	How do you feel about not using drugs/alcohol?	How has the prison gone about addressing (name's) substance misuse disorders?
Grief and loss	Who do you talk to if you're feeling sad or upset? If you are in a cell by yourself, do you feel better or worse?	Do you think (name's) mental health has improved or declined since she has been in prison? Does she self-harm? How often do you work with (name)? What conditions are you addressing? What sort of interventions have been initiated?
Self-esteem	What things make you feel good about yourself?	
Smoking	Did you used to smoke? When did you start smoking?	Was(name) a smoker?
Access to doctors	Have you seen a doctor since you have been here?	Is (name) under the care of a medical professional?

Indicator	Examples of women's questions	Examples of practitioner questions
Chronic conditions	Do you receive treatment, for example, for arthritis, asthma, or cardiovascular disease?	Is (name) being treated for any physical health conditions? How is this treatment administered?
Diet and exercise	Do you exercise? What foods do you mainly eat?	
Overall health	Is your health better or worse in prison?	Has (name's) overall health improved or declined?

3.6.5 Domain 11: Agency inside prison

Agency in a prison setting is extremely limited. The women in this study have virtually no scope for autonomous decision-making or action because prisons are governed under strict security- and containment-focused regimes. Accordingly, the women's daily routine is highly prescriptive, with decision-making mostly limited to program and work participation. 'Agency' was also explored from the post-prison perspective, which offered a little more scope for decision-making (see Table 11). The notion of 'hope beyond prison' invited the women to reflect on future possibilities and how they might plan for these.

Table 11: Agency inside prison

Indicator	Examples of women's questions	Examples of practitioner questions
Prison employment	Have you done different jobs in prison? Did you have to apply for them? Did you have to do job training?	Does (name) work? If not, what do you see as the barriers to this? What would be needed to facilitate prison work?
Security rating	Are you working towards getting a lower security rating? What things are you doing?	Has (name) committed to doing any of the prison programs? Has she discussed this with you?
Substance misuse	Why did you decide to do the 'Smarter Choices' program?	Are these programs suitable for her in terms of the level at which they are pitched?
Parenting	Would you like to do the parenting program?	Would participation in the parenting program be helpful for (name) regaining custody of her children?
Literacy and numeracy	Do you think more programs like maths or reading would be helpful?	How appropriate are educational programs for (name)?

Indicator	Examples of women's questions	Examples of practitioner questions
Staying safe	What things can you do in prison to keep yourself safe?	How do you address the issues of coercion and acquiescence?
Self-care	What things can you do in prison to make sure you stay fit and healthy?	In terms of life skills, what do you consider to be the priorities for (name) remaining safe and well?
Post-prison	How do you feel about getting out of prison? Do you think you will see your family and friends? What things would help you in the community? What gives you hope for the future?	What are the pitfalls for (name) when she exits prison? Will there be restrictions on family/peer associations post-prison? What do you feel are the community supports necessary for her to succeed? What is the process for getting (name) access to the NDIS?

3.6.6 Domain 12: Civic engagement inside prison

The examination of this domain was as brief as the domain of agency. As Table 12 illustrates, the women who were employed were asked to consider whether they felt their job was helpful to others and if their work gave them pride. This created opportunities to talk about respect and self-worth. The women not permitted to work (those accommodated in safe or detention units) were not asked these questions. However, all women, regardless of accommodation status, were asked, "Why did you want to help with this (research) project?" providing an opportunity for them to talk about their reasons for research participation.

Table 12: Civic engagement inside prison

Indicator	Examples of women's questions	Examples of practitioner questions
Care of community	Do you think your job helps other women? Do you think it helps the staff? Do you feel proud of the work that you do?	What is (name's) attitude to her job? Is she happy to work, or does she work because she has to?
Voluntary work	Have you ever been involved in any of the voluntary programs such as working for the RSPCA?	Has (name) ever talked about doing volunteer work? Could (name) do the RSPCA program? What, if any, are the barriers to this?

Research participation	Why did you want to help with this project?

In examining the above domains of social exclusion and the questions designed to obtain information about each, it is possible to see the interrelated nature of indicators and that they do not exist in isolation. Although this framework is an adaptation of that suggested by Lafferty et al. (2016), with modifications made to investigate the social exclusion of a particular prison population, the relational aspects identified in the broader social exclusion literature (see Chapter 2) were revealed. Pre-prison living arrangements, education, mental and physical health, and limited community involvement, all recognised by scholars as factors contributing to social exclusion (e.g., Besemer and Dennison 2019; Boardman 2011; Bowles 2012; Cochran et al. 2018; Foster and Hagan 2007; Kostenko et al. 2009; Mathieson et al. 2008), could be investigated using this framework.

3.7 Data analysis

Transcribed notes and interviews were coded thematically following Saldana's (2009) guidelines, which recommends two rounds of analysis. The first cycle of coding identified a range of social exclusion indicators, for example, family dysfunction, unstable living arrangements, physical and sexual abuse, low socioeconomic circumstances and education, substance misuse and general patterns of CJS involvement (for a complete list of round one coding indicators see Appendix 3). The second cycle coded the indicators into themes (see Table 13 and Appendix 4).

From the 58 indicators identified in the first round of coding, 14 key themes emerged: family, trauma, peers, education and employment, the CPS, the CJS, addiction and substance misuse, mental health, physical health, decision-making, goal setting, life skills, community participation, and care of others. Several indicators were present in more than one theme, such as family violence, grief and loss, and substance misuse. As previously discussed, these intersections are consistent with an analysis of social exclusion based upon a relational approach, in which domains, indicators and themes are interwoven to create an interpretation of social exclusion in the context of the prison population being investigated. These themes serve as the basis of the analysis in the following chapters.

Table 13: Identified indicators and themes

Indicator	Theme
Family dysfunction	Family

Indicator	Theme
Family violence	
Socioeconomic circumstances	
Indigenous communities	
Links to Elders	
Children	
Familial incarceration	
Child sexual abuse	Trauma
Family violence	
Homelessness	
Grief and loss	
Strip searches	
Friends	Peers
Bullying	
Respect	
Trust in peers	
Type of school attended	Education and employment
Year level exit	
Numeracy and literacy	
Prison program participation	
Job training in/out of prison	
Employment in/out of prison	
Foster homes	CPS
Unstable housing	
Indigenous communities	
Access to children	
Intergenerational foster care	
Victim/offender nexus	CJS
Onset of criminality	
Juvenile detention	
Barriers to justice	
Police	
Lawyers	
Judges	
Prison reception	
Remand	
Security rating	

Indicator	Theme
Prison staff Therapeutics	
Type of substance(s) Age begun Longevity of use Familial substance use	Addiction and substance misuse
Family violence Substance misuse Grief and loss Indigenous communities Homelessness Self-esteem	Mental health
Smoking Substance misuse Chronic conditions Diet and exercise	Physical health
Stay/leave abusive situation Prison employment Program participation	Decision-making
Security rating Substance misuse Parenting Literacy and numeracy	Goal setting
Living arrangements Self-care Personal safety	Life skills
Community-based programs Sport and recreation	Community participation
Voluntary work Care of family and/or friends	Care of others

3.8 Research challenges and limitations

An application to conduct prison research is a rigorous process, especially if the research involves people with vulnerabilities beyond their state of incarceration to include their status as women with cognitive disabilities and for some participants, Indigeneity. Ethics approval was

obtained from the Flinders University Social and Behavioural Research Ethics Committee. Institutional permissions were granted by the South Australian, Tasmanian and Queensland Corrective Services. Individual prisons gave informed and voluntary consent to participate in the research. Prisoners were assisted in understanding the study and the notion of informed consent by prison psychologists, ODMs, prison counsellors and ALOs. A Plain Language Statement was provided to potential participants four weeks in advance of the interview schedule, explaining the nature and scope of the research and what their involvement would entail. Information regarding practitioner – researcher discussions about the women formed a part of both the Consent Form and the Plain Language Statement (see Consent Form and Plain Language Statement Appendix 8). This was not an isolated explanation, but part of an ongoing process during the weeks prior to interview.

Examples of possible interview questions were issued to both prisoners and practitioners. A detailed description of the research project was provided to state Corrective Services, prison management and prison practitioners. Prisoner participants were assured of anonymity and the fact that they could withdraw from the study at any time. All prisoner participants were allocated a pseudonym, used throughout this dissertation. Practitioners have not been named but all agreed to the use of their job title. Consent forms were signed at the time of interview after responding to any preliminary questions and/or concerns. Participants were able to withdraw at this time if they did not want to proceed.

The difficulties associated with organising prison interviews cannot be overstated. Despite attempts to adhere to a pre-arranged timetable, the workings of the prison itself and the nature of the prisoner sample often made this impossible. Prison lockdowns, prisoner transfers, court appearances coinciding with interview times, medical and mental health issues, clashes with lawyer or prisoner advocacy appointments, and lack of available space in which to conduct the interview are examples of some of the issues that occasionally de-railed the interview schedule. Prison staff were extremely helpful in finding solutions, such as adding missed interviews to the following day's schedule, or organising alternative times on either the same day, or later in the week. Consequently, all prisoner participants were eventually interviewed. Additionally, this research involves women whose mental health was such that they were able to participate *on the day of interview*. This is important, as an agreement to participate three or four weeks prior to the scheduled interview does not always mean that on the allocated day, or even at the allocated time, the person will be in the right mental space to cope. Fortunately, this did not happen when the research was conducted. However, it is something that needs to be

acknowledged as a potential drawback for other researchers. Practitioner interviews were arranged around their schedules, with only occasional adjustments necessary.

In terms of conducting interviews with the women, various challenges arose. Some of them experienced difficulties with an oral history approach. Interviews privilege the spoken word, and this was more confronting for some than others. A flexible approach in which the interview did not necessarily commence with the schedule but allowed for more spontaneity, whereby we talked about generic topics such as foods they liked to eat, or pets they had owned, generally overcame this issue. Both myself and Indigenous participants benefited from the presence of ALOs. Without such assistance, several of the interviews would have been more difficult.

Although the research was bound by a strict methodological approach, the nature of the prisoner participants meant that once data collection commenced there was reliance on intuition, creative instinct and an ability to connect with the women. This was greatly aided by my own personal history of interaction with cognitively disabled people, a useful attribute in situations where not every interview could faithfully follow 'the script'. It enabled this possible limitation to be addressed by recognising familiar signs, such as loss of eye contact or agitated hand movements, signalling that the conversation needed to change direction and refocus elsewhere. For example, this situation arose if participants were upset by question. In these circumstances, it was useful to deflect from the immediate question by moving to an unrelated topic. Sometimes the women returned to the question of their own accord. In most cases, practitioners were able to provide information about the matter.

In several cases, the women did not want to move on from a question and this was sometimes problematic. For example, women who were fixated on the relationship with their partner or wanted to talk predominantly about their self-harming behaviours were less easy to divert. This necessitated halting the conversation via strategies such as coughing, apologising for the interruption, then moving to a disparate question, such as "Did you have any pets? What were their names?", before returning to the interview schedule. For women who did not want to answer a question, it was crucial to move immediately to something unconnected, such as places they had visited which they enjoyed, or a television show they liked. In general, practitioners were able to provide answers to unanswered questions.

Perhaps the most difficult aspect of the interviews with the women was their initial reluctance to talk about themselves, especially to someone they had just met. This was alleviated to a greater degree by the way in which I was introduced to them by prison staff. Introductions that went beyond just my name and included information about something separate to the research

and of interest to the women always worked well. For example, by way of a preamble, staff said things such as, “This is Julie, and guess what? She loves horses too, just like you!” This enabled the opening of a conversation that gradually progressed to the interview questions.

It is essential to keep in mind the complexities of researching in the prison environment generally and with this prison population especially. It is impossible to seamlessly move through an interview schedule, with one question following the next. As outlined above, interviews are akin to navigating a maze, whereby the researcher must be aware of where they have been and where they need to get to. The schedule cannot be rigidly maintained in either the order of the questions or how they are phrased. Questions occasionally need to be eliminated entirely, or rephrased, requiring judgements to be made instinctively. At all times the vulnerability of the women was the first and foremost consideration. Researchers come to the interview from a position of privilege and a worldview that is vastly different to those being interviewed. In no way can this be allowed to intrude on the conversation. To do so undermines the notion of an exchange between two people in which mutual respect and dignity are paramount.

A further consideration related to prison research more broadly is the concept of ‘suspension of belief’ (Saleebey 1992). This requires the researcher to suspend beliefs about a prisoner’s status as a thief or a drug addict and enter their world as they present it (Wormer 1999). Displaying a willingness to listen without judgement ultimately encourages the emergence of the person’s own truth. For this research, the importance of the ability to put to one side a person’s identity ascribed to them by way of their offence history was central, especially when interacting with vulnerable women accustomed to being judged by others. For them, knowing that I understood that ‘what they did’ does not make them ‘who they are’ was crucial in generating a conversation in which they felt secure and respected.

Moore and Scraton (2014: 59) point to a component of prison research that is sometimes overlooked, and that is the need to keep state Corrective Services and the prisons themselves ‘on side’. They state that, “At each level restrictions are both demanded and imposed by the prison service and the specific prison. Aspirant researchers also impose self-regulation to secure access, retain cooperation and maintain relationships for future work”. Reassuring Corrective Services and the individual prisons that the intention of the research is not to denigrate the prison or those who work there is crucial. Positive relationships are essential if researchers are to be granted access, not only for the immediate project, but for future projects and for future researchers. Damaging those relationships effectively closes the door for others who wish to

conduct prison research, and so the responsibility of maintaining respect, cordiality and flexibility when not all goes to plan is fundamental.

The interface between research and emotion was ever-present. For the participants, I was sometimes viewed as a 'lifeline' and a conduit to the outside world. Many of them had never had a visitor in prison, at least not one who was something other than a legal professional, doctor, or dentist. From my side of the table, it was often difficult to refrain from showing an overly emotional response to their deeply moving stories. Several of the women regarded my role as that of offering friendship and support. This necessitated continued reference to my actual role and the fact that I had no capacity to effect change to their circumstances, either inside or outside the prison. This is an issue recognised by Michell (2020), who observes that "some [research] participants… expected or hoped I could do more to alleviate their suffering in the present". Several participants begged me to "just contact my [partner; children, mother; sister] for me", reciting the relevant mobile telephone numbers without hesitation. There were numerous requests for assistance with contacting lawyers and finding out about court dates, being asked to approach prison authorities on their behalf to change a particular rule or regulation, or to see if their security classification could be modified, and several who just wanted me to "contact the government" to get the whole system changed.

Additionally, there is a constant challenge with qualitative research, and certainly in a project such as this, to ensure that the research method extends beyond intrusive curiosity to achieve more than the "telling of sad stories" (Hewitt 2007: 1150). However, I took encouragement from the words of Liebling (1999: 149):

> The absence of 'pain' or emotion from quantitative (and indeed, most qualitative) research accounts of prison life has always baffled me. Research in any human environment, without subjective feeling is almost impossible (particularly, I would argue, in a prison). These feelings – belonging to staff, prisoners and researchers – can be a significant guide to, or even source of, valuable data.

Research in a correctional environment invariably gives rise to emotional responses, not only from the prisoners but also from the researcher, and this must be dealt with during and after the completion of the research (Daggett and Camp 2009; Lucic-Catic 2011). The significant impact of listening to life stories of disadvantage and abuse, especially in a situation where interviews are compressed into a schedule allowing little time between each one, was something unforeseen at the commencement of the study. The emotional repercussions are significant and something that scholars considering similar research need to be conscious of. This challenge was addressed by first acknowledging that it existed. Speaking with prison practitioners in informal settings such as their staff rooms, was helpful. On returning home, further

conversations with others who have conducted prison research also assisted with gaining perspective. This directed the focus to the contributions of the research participants and a research objective of fulfilling a promise to the women that their stories mattered and would be heard. Concentrating on the reasons to research, as discussed in Chapter 1, provided motivation and commitment to ensuring the promise was kept, and enabled a certain distancing from the more emotive aspects of the process.

Finally, caution must be exercised in not overestimating the scope of this research. Although these personal narratives provide valuable insight into the experiences of this group of women, this is accompanied by an acknowledgement that their lived experiences may be different to women in other places and other prisons. Additionally, there are women who fit the sampling criteria whose personal stories cannot be presented because their mental health is substantially compromised. This means their lived experience is unlikely to be included in research projects such as this because it presents too much of a risk to them. This is regrettable from the point of view that their stories are important in providing important information about the circumstances leading to a situation in which their mental health has been so severely affected as to prevent a conversation with an external person. Therefore, the findings presented in the following chapters should be viewed as indicative rather than conclusive.

3.9 Conclusion

This chapter explained the study's methodology. The utility of social exclusion was discussed, highlighting the application of not only the widely accepted determinants of social exclusion such as unemployment, unstable housing, low education and CJS interactions, but associated theoretical perspectives that examine social exclusion in the light of less measurable aspects such as trauma, mental health and substance misuse. Reasons for the use of narrative were provided, emphasising the centrality of the women's voices as experts of their own experience. Research design such as sampling procedures, data collection, measurement and analysis were also presented. Finally, the ethical considerations, challenges to and limitations of the research were clarified.

Chapter 4: Pathways to Prison: Pathways to Social Exclusion

4.1 Introduction

Chapter 4 presents the first of the study's findings and will be used to address Research Question 1: How does social exclusion contribute to the trajectory of women with cognitive disabilities into prison? Drawing on the women's biographies outlined in Appendix 5, this chapter explores their lives prior to incarceration. The chapter is framed by the domains of social exclusion identified in Chapter 3 and explores these domains: formal and informal networks, trust and safety, health and wellbeing, agency, and civic engagement—*outside prison*. Key themes arising from analysis of individual indicators, depicted in Table 13 in the previous chapter, will be discussed in the light of the women's narratives. These include family, trauma, peers, education, addiction, mental and physical health, decision-making, life skills and community involvement. Importantly, the connections between domains, indicators and themes are revealed, illustrating the relational aspects of social exclusion and the fact that no one indicator exists in isolation.

Chapter 4 provides preliminary support for the dissertation's central proposition that incarceration and cognitive disability contribute to social exclusion, and that social exclusion itself is a contributing factor to offending and subsequent trajectories of the study's participants through the CJS. It is important to keep in mind one of the key aspects of this research, cognitive disability. For this group of women, the presence of a cognitive disability manifestly impacts impulse control, decision-making and susceptibility to coercion, all of which contribute to repeated interactions with the CJS. This chapter illustrates the ways in which cycles of offending/reoffending are generated not only by patterns of behaviour that many of the women find difficult to change, but also by social and structural elements beyond the women's control. The behaviours that are routinely criminalised have been shaped by histories defined by trauma, disrupted communities, unstable families and accommodation, and exclusion from institutions such as health and education. The women and their stories are unique, and yet the common thread of exclusion runs through many of the narratives, emanating from circumstances that, for the most part, originated during childhood. As adults, their lives continue to be defined to a greater extent by the actions of others, as the remainder of this dissertation demonstrates.

4.2 Domain 1: Informal networks on the outside

In considering Domain 1, which focuses on the women's personal stories in relation to family life and socioeconomic circumstances, peers and bullying, histories of abuse, homelessness, unstable accommodation and disrupted Indigenous communities, a picture emerges of the symbiotic relationship between the indicators of social exclusion identified in Chapter 3. In the foreground of this picture is cognitive disability and the vulnerabilities that increase the susceptibility of the study's participants to abuse, bullying, entrenched economic disadvantage and the impact of grief and loss. It would be fair to conclude that in isolation each indicator has the capacity to foster social exclusion to a greater or lesser degree. However, this group of women are situated on a "multi-dimensional continuum" (Silver 2007: 1), moving towards a state of segregation, discrimination and marginalisation in which they are systematically excluded from social involvement.

4.2.1 Informal networks: Family outside

As a thematic grouping, *family* consists of interrelated indicators such as family dysfunction, poor socioeconomic circumstances and ties to Indigenous communities and Elders. Drawn together, the women's narratives around this theme advance the paradigm of social exclusion by considering the key element of cognitive disability in the context of families who, for the most part, are impacted by substance abuse, unemployment, low or no income and unstable living arrangements.

4.2.1.1 Socioeconomic conditions and family dysfunction

During the research process, the relationship between environmental disadvantage and family dysfunction was highlighted by several of the women's stories. 'Environmental disadvantage' broadly refers to family dependence on welfare, such as Centrelink payments; poor parental health, often as a result of substance misuse; domestic violence; little oversight of children combined with overall poor parenting; and, in general, low parental educational attainment (Clark et al. 2000; Sadowski et al.1999). In much the same way as social exclusion and incarceration are mutually reinforcing, low socioeconomic status and family dysfunction share a similar relationship in that disadvantage and family dysfunction augment one another.

The women in this study predominantly come from deprived backgrounds. For example, Sally's family live in a remote Indigenous community that is economically impoverished, which according to the prison psychologist, is mostly due to very high levels of unemployment exacerbating the volatility of an already unpredictable environment. Sally has never known

family stability, and at the time of interview was incarcerated for assaulting her mother and sister, who Sally said had '"asked for it" because they were "being mean to me". Caroline also lived with poverty and family dysfunction all her life. Both the prison ODM and ALO described the house in which she lived with her grandmother as being in a complete state of disrepair, full of asbestos and in desperate need of replacement. Drug paraphernalia was everywhere, the residence housed a transient population of other family members and acquaintances, and the ALO commented that Caroline has never known any familial or parental stability. The ODM said that Caroline's two children, one of whom was born as a result of the rape of Caroline, and the other because of an exchange of sex for drugs, lived with Caroline's aunt. Although the ALO contacted Caroline's mother on several occasions, asking her to help with the children because the aunt was having difficulty coping, the response was always a definitive 'no'. The ALO said, "Caroline's mum doesn't give a shit about any of them. She yelled abuse at me when I rang to ask for her help".

Miriam, the oldest study participant at age 68, talked about her family life, which was characterised by incest that affected her up to the time she moved out of home at age 18 (this might cautiously be proffered as a background to Miriam's own offending - the sexual abuse of her three children). She spoke about how, after her marriage ended, she lived in a trailer with her three children in an area typified by poverty and unemployment. Bronwyn too comes from low socioeconomic circumstances. She talked about her elderly father who collects cans and other pieces of metal from around the neighbourhood as a means of earning money. The prison psychologist said that Bronwyn's father was 77 years old and the primary carer for Bronwyn (when she is not in prison) and Bronwyn's sister who is also cognitively disabled. An ODM provided background information about Maddie, whose parents were both drug addicted. Although an older sister looked out for her, Maddie was mostly left to her own devices. She did not attend school and had her first baby at age 14. Mary spoke about living in a chaotic family environment that she referred to as "a nightmare" in which she experienced substance use, unemployment and domestic violence. She had a baby at age 12, the first of six children, and apart from her late father, has had no contact with her biological family since that time. She was aged 44 years at the time of interview. She said, "it was a nightmare at home. I hated my mother. Dad was a bit better. He came to visit me a couple of times when I first went to prison [age 22]".

These stories resonated with the vast majority of the women in this study. As Chapter 2 illustrates, there is abundant social exclusion scholarship that draws on socioeconomic disadvantage and the notion of dysfunctional family life as factors contributing to social

exclusion (e.g., Adam and Potvin 2017; Atkinson 1998; Hobcraft 1998; Millar 2007; Pate 2009). Easteal (2001: 88) argues that there is an "equation between prisons and dysfunctional families" and that one of the effects of living in a dysfunctional family is the internalisation of hurt and anger, which later finds expression in the use of substances and, for some, violence.

4.2.1.2 Indigenous women: Damaged communities and how 'looking white' is perceived

The study's Indigenous participants revealed a range of perceptions about their families and communities. For some, connections with communities either never existed, or were tangential at best. For others, their sense of confusion in prison was substantially based on their separation from community, family and Elders. As previously noted, Sally's community is volatile. The prison psychologist described a situation in which many of her descendants suffered forced removal from their community and were placed on mission stations. Today, there are numerous historic clan issues that are problematic, mainly due to people being brought in from other communities, leading to conflict among the Elders. The practice of removing children deemed 'at risk' continues, further undermining the stability of the community. During her interview, Sally did not refer to any of these circumstances. Even though she suffered abuse while living there, she constantly repeated, "I have to get out of here. I have to get back to my community". For Sally, community represented her bedrock, and her confusion over not being able to return undermined her mental and physical health, something noted by both the psychologist and the ALO. Belinda also grew up in a community where drugs, alcohol and violence were prominent and she imitated these patterns from an early age, which the psychologist believed was the catalyst for addiction and related offending. Belinda said that she stayed in her community until she was 14, after which time she left to live with her father in a big town. She went on to say that she has had no contact with her community since being incarcerated, although she expressed a desire to reconnect when released from prison. Much like Sally, the juxtaposition between Belinda's community as simultaneously a place of cultural connection and one of insecurity was reinforced when she said, "I want to go back there, but lots of shit happens".

A further issue that arose during conversations with the study's Indigenous women was the tension between Indigeneity and 'looking white'. Behrendt (2012) argues that Indigenous people of mixed heritage who are light-skinned and therefore not easily identifiable as Indigenous, are thought by some not to be 'real' Aboriginal people. This tension was apparent during several interviews. Unhappiness regarding siblings, and even their own children, who 'looked white' permeated several of the women's stories and was a cause of anxiety. Melanie was resentful of her partner's sister who "looks white. She's not. She's Aboriginal too, but she looks white because she had a white dad". Melanie felt that compared to her sister-in-law's

children, her own children received far less family attention because “they’re black”. Similarly, Jennifer’s sister, whose father was white, was cared for by his side of the family because she “was more white than me”. Jennifer referred to that side of the family as “posh”. Susan is Indigenous on her father’s side. Her community and cultural heritage were important to her: “I’m still learning about them [ancestors]. This is really important. The boys’ [Susan’s sons’] carer is teaching them”. She said that she did not feel safe or comfortable in spaces predominantly occupied by white people and spoke about the feeling of always “being watched”. Susan also believed that there is one law for white people and another for Aboriginal people. She said that she knew there were white people who had “done stuff worse than me” but were not sent to prison.

A concern expressed by Susan, Theresa and Alice centred on the loss of identity arising from the uneasy relationship between Indigenous people and their communities, and non-Indigenous people who do not have an identity linked to a heritage spanning more than 40,000 years. A joint research project (between the Larrakia Nation Aboriginal Corporation and University of Tasmania) highlights the damaging effects of white materialism and individualism that undermine Indigenous practices of trust and reciprocity (Walter et al. 2016). The study’s Indigenous women whose siblings were adopted by the ‘white’ side of the family believed that as a result of this they were denied the potential to learn about their Indigenous heritage and robbed of the opportunity to maintain connections with family and community. This is a perspective supported by scholars such as Atkinson (2002) who argues that Indigenous grief arising from the loss of knowledge of who they are is a significant factor when considering the cumulative trauma of colonisation.

Additionally, Grieves (2009) highlights the loss of spirituality and language as closely connected to the destruction of Indigenous social and emotional wellbeing. For example, Theresa felt strongly about the fact that her ‘white’ half-brothers and sisters denigrated Indigeneity, and this contributed to her own anxiety and depression. She said they had no knowledge of their ancestry and no desire to learn about it, which she could not understand. In Caroline’s case, where she was incarcerated for drug and alcohol-related offending which severely compromised her mental health, her only sense of security came from ties to her community in the Northern Territory. She spoke her language and was knowledgeable about her ancestry.

The tension between maintaining Indigenous culture while simultaneously striving for ‘progress’ and ‘socioeconomic productivity’ brings to the fore the debate of ‘assimilation’ versus ‘self-determination’. As Dockery (2010) argues, the sacrifice of Indigenous culture in

the name of economic development has had a wholly damaging effect on the spiritual and cultural life of Indigenous people, as well as the generational transmission of multifaceted harm. 'Assimilationist' outcomes, pursued at the cost of cultural identity, have undermined Indigenous communities. In terms of social exclusion/inclusion, Hunter (2009: 60) argues that "If social inclusion policies ignore cultural issues entirely, then policy-makers will lay themselves open to the criticism that they are just updated versions of assimilation practices". What is evident is that practices such as the forced removal of children, which continue to disrupt communities like Sally's, are closely associated with higher rates of intergenerational CJS involvement. Regarding cultural differences as a 'problem', which was a driver of mid-20th-century policies leading to the Stolen Generations, ensures only entrenched marginalisation (Hunter 2009). Discussions of 'social exclusion' that neglect to include as their core argument Indigenous self-determination inevitably fail to address the cultural divide between Indigenous and non-Indigenous communities.

4.2.2 Informal networks: Trauma outside

A consideration central to this dissertation is that cognitive disability can increase a person's vulnerability to abuse. Sullivan and Knutson (2000) identify that children and young people with cognitive disabilities are more likely to be a victim of some sort of abuse compared to those without a disability (also see Wigham and Emerson 2015). Common responses by women to abuse-related trauma include anger and aggression. However, trauma-related distress in women with cognitive disabilities may be interpreted as challenging behaviour, or even misdiagnosed as psychosis. As Wigham and Emerson (2015) argue, this often results in the person being labelled as 'difficult' or 'rebellious', further reducing their chances of receiving interventions aimed at addressing abuse-related trauma.

4.2.2.1 Family violence and abuse

Stathopoulos and Quadara (2014: 4) maintain that, "the clinical literature on child sexual abuse and cumulative harm has found that early onset life-course victimisation results in complex mental health problems that profoundly affect self-regulation, healthy attachments, and cognitive and neurological development" (also see Fallot and Harris 2002). Frederick and Goddard (2007) contend that early childhood trauma contributes to social disadvantage and exclusion (also see Bromfield and Holzer 2008). In conducting this research, it was one thing to read the work of these well-credentialed scholars; it was quite another to sit with women who have been so severely abused as children and adults that the likelihood of them ever having a life that is not affected by these experiences and its corollaries, such as substance misuse, self-

harm and mental illness, is unimaginable. Reflective of Widom et al.'s (2008) research, which concluded that childhood victimisation leads to an increased risk of lifetime victimisation, the accounts shared by the majority of the women in the present study revealed commonality—abuse as children, followed by repeated patterns of abuse in adulthood.

While the women's stories presented here are just the tip of the iceberg in terms of both this research project and the wider reality, they illustrate the way in which violence perpetrated against women and girls puts them at risk of incarceration, funnelled into the CJS not as victims, but as offenders. Changes in arrest, prosecution and sentencing policies, which have seen the introduction of more punitive approaches to punishment, criminalise women's efforts to survive, escape and cope with abuse (Baldry 2010; Cunneen et al. 2013). Drawing on the women's experiences of trauma, their narratives highlight its centrality in shaping their personal biographies. The interface between trauma and criminalisation, and the significance of this connection in contributing to a state of social exclusion that lays waste any notion of 'life-chances', is brought into sharp focus by histories largely defined by vulnerability to a range of abuses.

From the age of nine onwards, Amelia was sexually abused by her father, which continued during her teenage years. Amelia married at age 18 but was severely beaten by her husband. Several times during her interview, she pulled the shoulders of her t-shirt across to show the damage. Both collarbones were dramatically enlarged and deformed. Amelia said that her husband also broke her right arm, and this caused her constant pain because it remained untreated. He smashed her face with a hammer, breaking or knocking out most of her teeth. She ran away, ending up homeless and on the streets where her vulnerability saw her taken advantage of numerous times. She said, "it's not ok for a bloke to get drunk and use me for sex. I'm a human being. I'm not just for sex". Rachel was also sexually abused by her father. She said that her mother was "mental" and physically harmed her and her brothers and sisters. When asked about what led to her committing crime, Rachel said, "because dad done some stuff to me".

Jennifer experienced violence from when she was little. During the time that she lived with her mother (prior to going to juvenile detention), she witnessed her mother's various partners being extremely violent. At age 10, Jennifer protected her mother by hitting one of the men over the head with a frying pan. For this act, she was severely beaten by her mother. At age 11, Jennifer told her mother that she had been raped by an uncle. Her mother's response was to hold Jennifer's hands on a hot stove, leading to permanent deformities. Jennifer is a violent but also very frightened young woman. The prison psychologist doubts that she will ever fully recover.

Sally suffered physical and sexual abuse at the hands of her family. She was 'passed around' within her community who, according to the prison psychologist, did not understand her cognitive impairment and the acquiescence that is part of it. Bronwyn was raped at age 17. It is believed that a family member was responsible. The psychologist said that Ruth also had an extensive history of sexual abuse, beginning before the age of eight. She was also sexually assaulted in a camp for homeless people. Kelsey spoke about being raped by a friend of her father's when she was 12 years old. She told her father, who then murdered his friend. Kelsey's father is now serving a 25-year prison sentence. Like Ruth, Molly was repeatedly raped as a child, and was pregnant at the time of interview, which the psychologist said was the result of a sexual assault.

High levels of domestic violence characterised Melanie's community, and she was flagged as both a perpetrator and victim of domestic violence. Melanie was an example of the normalisation of violence. She could not understand why she was in prison when she was surrounded by family and community violence and her own violence was a retaliation against assaults committed against her. Similarly, Belinda's community was very violent and she was physically and sexually abused. Like Melanie, she regarded this behaviour as typical, and her concept of 'abuse' centred more on people fighting her to take her drugs than the sexual assaults that she did not view as out of the ordinary.

These examples are representative of the lived experience for many of the women who contributed to this study. What is troubling is the fact that for women such as Melanie, Belinda and Sally, abuse sustained in childhood served to normalise this behaviour, so that maltreatment as they aged was not viewed as such; rather it was thought to be usual and something that happened in all families. The presence of a cognitive disability increased their susceptibility to victimisation.

4.2.2.2 Homelessness

In the context of this study, homelessness was closely connected to the circumstances described above. The severity of abuse at the hands of her husband saw Amelia run away when she was 20, but with no money of her own, she became homeless. She tried to get into homeless shelters, but said that most of the time they did not have space for her. She also said that they "kicked me out during the day" and so it was "just easier to sleep in the park, or under a bridge if it was raining". Rachel, who was sexually abused by her father and physically abused by her mother, ran away at age 15. She said, "I ran down the street. I didn't have nowhere to go. I remember I slept in a playground once". Molly experienced homelessness and talked about staying "down

by the river". Her list of possessions when she arrived in prison consisted of a suitcase, bag of wine, vinegar, bracelet, book, advent calendar, some toiletries, purse, lighter and $1.25 in coins. Georgina was left homeless after aging out of the foster care system.

Susan was homeless from the age of 16, living on the streets for over three years. Sometimes she slept in a park and sometimes close to a police station. She said that she always tried to find a place that had good lighting so that she felt safe. Susan was homeless during pregnancy and said that it was "hard to get comfortable". When she went into labour, someone called an ambulance and she was taken to the hospital. The baby was immediately removed by CPS. Similarly, Ruth was in a violent and controlling relationship and so she ran away, remaining homeless for several years prior to incarceration. She had previously been given parole, but had it suspended for failing to report to her parole officer. As part of her parole order, she was required to report to the parole office once a week, which required a walk of around 10 kilometres each way, starting from the homeless camp where she was staying and walking into town. Ruth found this extremely difficult, so she breached the order and was sent to prison.

As evidenced by Figure 1, the majority of the women were impacted by unstable living arrangements. Seven of the study's participants reported having been homeless. Twelve women reported unstable living conditions and only three had no significant accommodation issues.

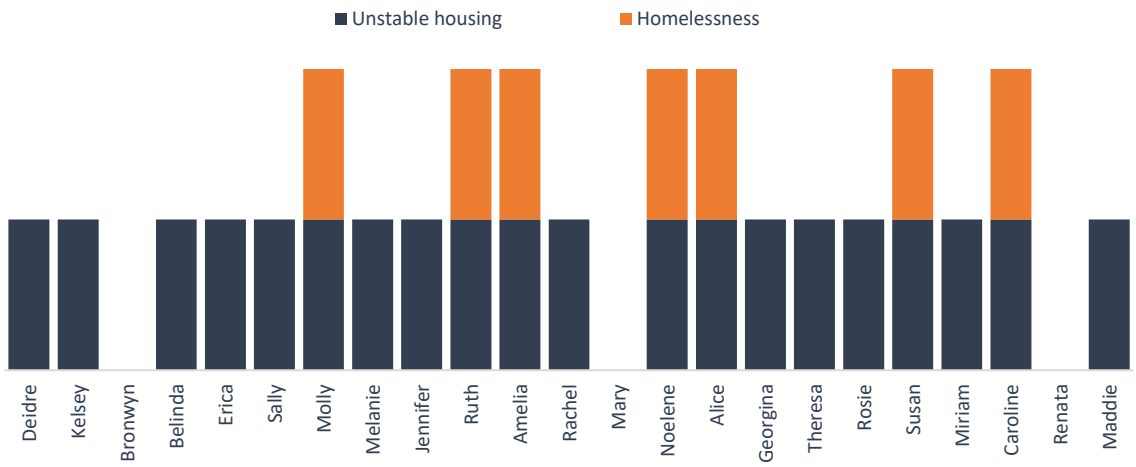


Figure 1: Pre-prison living arrangements of study participants

In considering the women's stories, the most common phrase was 'running away'. Various studies point to the fact that abused women generally make several attempts to leave their abusers, but often return because they are financially dependent on them (e.g., Gorde et al. 2004; Jeffries and Newbold 2016). Additionally, as Susan highlighted, knowing where to go or who to turn to was problematic. The dispersed location of services and lack of coordination

between services left her confused to the point where she simply abandoned any effort to get help. For Ruth, the whole notion of 'an appointment' contributed to the inaccessibility of services. She did not own a phone, she had run away with just a few dollars, and as with her inability to adhere to parole meetings, having to walk many kilometres to an office was unrealistic. In Molly's case, rather than attracting the attention of support services, her mental health and substance addiction attracted police intervention. Although Molly was known to mental health agencies, little or no communication between them and other support networks, such as women's shelters, meant that there was only ever a patchwork model of care, offering fragmented support that was highly dependent on levels of public and government funding.

This is an issue that has been identified for some time (Cameron et al. 2014) and a problem that particularly impacts women with cognitive disabilities who are homeless. While the literature around this topic is limited, Oakes and Davies (2008) point out that cognitive disability greatly increases the susceptibility of homeless people, especially women, to various harms, as well as impacting their ability to respond to practitioners from relevant services because of lack of comprehension of verbal and written information (also see Spence et al. 2004). As discussed in Chapter 2, there is a significant body of literature that demonstrates causal links between homelessness and incarceration (e.g., Baldry et al. 2006, 2013; Fischer et al. 2008; Metraux et al. 2007; Moschion and Johnson 2019). Homelessness, particularly if the person is in a public space, exposes them to police interventions due to public order offences such as trespass. In considering the women's narratives, the overriding impression was the absence of assistance or support in the community, and as such, CJS interventions were more a probability rather than a possibility.

4.2.2.3 Grief and loss

Grief and loss formed a part of the narrative of nearly every participant, arising from loss associated with familial death and suicide, as well as the loss of children to CPS. The pains of grief and loss experienced by the Indigenous women who contributed to this study are worthy of far more than the scope of this dissertation allows; the significance of loss of land, language and culture, as well as the fracturing of family and community solidarity, cannot be overemphasised (Wanganeen 2014; Wynne-Jones et al. 2016).

Suicide touched several of the study's Indigenous women, and their stories brought to light how very little was done to support them following these deaths. Belinda was emotional in describing the suicide of her 27-year-old sister when Belinda was 15. Her sister, with whom Belinda was very close, hanged herself, and this had significant and ongoing ramifications for

Belinda's mental health. Belinda discovered her sister in the back yard and helped to cut her down. Jennifer was also touched by familial suicide. Her father hanged himself in the back shed when she was seven. Jennifer was the one who found him and was present when he was taken down. Although prison practitioners were aware of these losses, they said that prison was not a place in which such trauma could be addressed.

Alice spoke about the loss of her daughter who died two months prior to the interview. Alice thought she was about six years old and said that she had no idea what happened to her. Alice's aunt had custody of the little girl and Alice had no contact with either the aunt or her daughter. Alice also became very distressed when talking about her older sister, who gave birth to premature twins at 24 weeks. The little girl died and the little boy was still in the ICU at the time of interview. Alice said, "This is why I've hurt myself so much. They are my niece and nephew". Shortly before the interview took place, Alice's younger brother attempted suicide on his fourteenth birthday. Alice said it was because he has lost over eight people in the past two years. She said that he continued "to go downhill" and was living with Alice's mother, who was feeling the strain of caring for him. Alice's mother was on anti-depressants and Alice worried constantly about her younger siblings and her mother.

Some of the risk factors and disadvantaged circumstances affecting the study's Indigenous participants also affected the study's non-Indigenous women. Mary's sense of loss centred primarily around separation through incarceration from her six children, the first of whom was born when Mary was only 12. Her oldest son, aged 32 years at the time of interview, was terminally ill with AIDS, which had been passed on to both his children. He contracted AIDS through sharing needles. Mary said that her son would be better off in hospital, but he kept discharging himself to go out and buy drugs. Mary desperately wanted to see him. She said, "I guess I'll get to see him at his funeral". Erica, the study's youngest participant at 17 years of age, referred constantly to the death of her father, with whom she was very close. During the interview she said, "It was his birthday yesterday. I miss him". She also said, "I'm the bad child in my family. Dad would have to come to visit me [in prison]". Erica's therapeutic interventions were focused predominantly on her self-harming behaviours, which practitioners viewed as mostly due to the loss of her father.

Lepage (2012: 6) notes that the social exclusion of people with cognitive disabilities attempting to deal with cumulative and unresolved losses often arises from the "systemic barriers (e.g., inadequate resourcing of services; social attitudes and ideological approaches that preclude consideration of grief needs)", contributing to what she refers to as "disenfranchised grief" which underpins their exclusion via a disregard for an individual's need and/or capacity to

grieve (also see Blackman 2001; Clute 2010). Additionally, grief and loss because of suicide attracts its own kind of stigma and social distancing. Belinda said, “I don’t really talk to nobody about it [suicide death of her sister]. She was my best friend”.

In relating the women’s stories via the written word, it is impossible to convey the level of emotion revealed by the women as they spoke of the loss of those whom they loved deeply, or of the grief associated with the separation from their children and communities. While remaining mindful of Hewitt’s (2007: 1150) warning for researchers to go beyond the “telling of sad stories”, in this instance, the telling of the women’s stories is indeed sad. They carry a burden of grief and loss that has been routinely dismissed by most of the people in their lives, and beyond the sadness of the stories is the inexplicability of the lack of community support in providing a ‘soft place to land’.

4.2.3 Informal networks: Peers outside

Chapter 2 highlighted the role of peers in precipitating antisocial and offending behaviour. It was apparent when talking with a number of the women that the desire for acceptance and inclusion overshadowed the risk of the possible consequences of antisocial or criminal conduct. Bullying and coercion are not uncommon, and the strong motivation to ‘fit in’ and be part of a group is a driving force (Maxey and Beckert 2017). The relationship between negative peer associations and social exclusion is evidenced by lower participation in social and recreational activities, resulting in greater loneliness (Maxey and Beckert 2017; Solish et al. 2010). As Chapter 2 identified, ‘scapegoating’ by peers into acting as an accomplice to crimes is often the consequence (Dickson et al. 2005; Porter 2004). QAI (2015) maintain that peers are frequently responsible for ‘coaching’ inappropriate behaviour, and several women in this study were the victims of this form of abuse.

Deidre described her peers as “associates” rather than friends and said that they constantly made fun of her. “They’d set me up so that I’d end up getting in trouble”. Deidre was frequently taken advantage of, with school peers exacting favours from her, such as carrying their schoolbags, or being allocated the job of fetching the ball during games when it was kicked or thrown ‘out of bounds’. Deidre stole money from her mother’s purse to pay the group to be friends with her. Rachel too wanted to be liked and accepted, and this desire was directly linked to her offending. At the urging of peers, she set fires in two large stores, as well as burning down her aunt’s house. By the time the fire brigade and the police arrived, the ‘friends’ were long gone, and Rachel was arrested, charged and sent to juvenile detention.

Theresa was badly bullied at school. At the time of interview, she was 44 years of age, but despite the amount of time that had passed, this was something that continued to affect her. Theresa said that she was bullied because she was overweight. By the age of 16, she was bulimic, and this eating disorder was still present, causing her to be significantly underweight. When asked if she thought that people liked her more because she was thin, she said, "It doesn't matter. They've always made fun of me. I'm just used to it". Susan talked about playing cricket when she was little but was bullied while on the team. "The other girls used to say that it was my fault when we lost, but one day, we won because of me". When talking about peers, Rosie referred to being called "fat and lazy" at school. She tried to garner friendship by breaking school rules and being rude to teachers. Rosie was eventually barred from school, having been charged with arson. She was encouraged by a group of girls to set fire to the toilet block. Although the group helped start the fire, they ran away, leaving Rosie behind. She was apprehended by staff, expelled and given a police caution.

Susan talked about her introduction to substances during her school years as part of a peer group. She was encouraged to take drugs and then to commit offences such as damage to property, graffiti and assaults. This was an experience shared by several of the women. Noelene was introduced to drugs by people she thought were her friends. When she was unable to pay for them, they persuaded her to prostitute herself in public spaces, sometimes in exchange for just $1.00. Noelene is profoundly cognitively disabled and her recollection of these experiences was immensely sad, especially her bewilderment over the way in which she was laughed at by others when the police intervened. Noelene said that she has been bullied most of her life, often because of her weight, and with the exception of a neighbour's child who was a playmate when she was 10, has never had a friend. The prison psychologist spoke about the way in which Sally was bullied at school, not only because of her cognitive disability, but also for her lack of personal hygiene. This has continued in prison.

For most of the women, the concept of 'respect' was closely aligned with 'being liked'. If they felt someone liked them, they also believed they were respected. Conversations about respect elicited various responses. For example, Amelia said, "I just want to go back to my carer. He helps me with day-to-day life. He is good at communication and treats me with understanding and respect". Bronwyn felt that her lawyer treated her in a respectful way and that the judge in her latest court hearing showed her respect, which was different to several of the women, who, like Kelsey, said that "the lawyer didn't give a fuck". It was difficult to engage most of the participants in a conversation about two-way respect, although Miriam and Mary, two of the older women in the study, identified the reciprocal nature of respect. For the younger

participants, like Rachel, Georgina and Erica, respect was seemingly one-directional, in that they referenced 'lack of respect' in terms of what they received, rather than what they gave. However, without exception, every participant in this study was courteous and respectful throughout their interview. While the concept of mutual respect may not necessarily have been easy for them to articulate, it was clear that in practice, the giving and receiving of respect was instrumental in guiding the course of interviews.

The women's narratives indicate that over the course of the women's lives their peers treated them differently to non-disabled friends and acquaintances. Bullying was a common theme, with acquiescence to coercion notable, especially in the commission of antisocial or illegal acts, as the women tried to garner friendship. Respect was mostly viewed as one-directional, although the older women identified two-way respect as an important component of relationships.

4.3 Domain 2: Formal networks on the outside

Domain 2 narratives demonstrate the way in which exclusionary practices are reinforced by formal networks outside prison. Lack of inclusion in education and employment, with a contemporaneous overrepresentation in the CPS and CJS, contribute to cycles of offending that feed into further entrenchment both systems. The incarceration of family members heightens the women's vulnerability to CJS interventions as they imitate patterns of behaviour such as substance misuse and violence. The women's lack of capacity to manage and cope with police interviews and court appearances, or to understand legal processes, reinforces exclusion within the system that punishes them. The victim-offender nexus also needs to be considered in the light of cognitive disability, especially given the elevated rates of domestic violence committed against cognitively disabled women and the fact that a violent response on their behalf is rarely without provocation. In tandem with Domain 1 indicators (informal networks outside prison), which socially exclude the women through lack of family, social and community bonds, indicators in Domain 2 continue to generate social exclusion through a range of institutional protocols that alienate vulnerable and marginalised people.

4.3.1 Formal networks: Education outside

As the following narratives reveal, participation in school was minimal, and the socio-cultural contexts of education were, for the most part, uninformed by inclusive ideals. Robinson and McGovern (2014: 7) point out that many children with a cognitive disability are socially isolated at school and that "chronic teasing and harassment impacts upon students' confidence,

mental health and sense of belonging at school, reinforcing their loneliness and leaving them in an increasingly vulnerable social and emotional position" (also see Caldas and Bensy 2014; Stalker and McArthur 2012).

Low educational attainment was a consistent feature in the lives of the women. For some, their cognitive disability contributed to an early exit from school. For others, dysfunctional family life meant that education was not a priority. Several transitioned to Special Schools or Special Units within a regular school setting. Substance abuse from an early age contributed to interrupted education. Most of the women said they "hated school". Several reasons for this emerged. Experiences of bullying and manipulation meant that school did not represent a safe space. Lack of friends and little engagement with extra-curricular activities left many feeling disconnected and alone. When asked if they had a favourite subject, most said "no", although Bronwyn "quite liked school", identifying cooking and art as two things she liked to do. She went to Year 10 followed by three years in the Special Unit as part of the school's High and Additional Needs Program. This included an Integrated Skills Program catering to students with cognitive disabilities, including life skills, recreation, literacy, numeracy, cooking and nutrition, and computing. However, as Slee (2013) argues, 'special units', such as the one attended by Bronwyn, are not necessarily the answer. This type of separatist education, cocooned in language of 'inclusivity', actually creates greater exclusion, creating concerns about 'who's in and who's out' in the regular school setting, how that is determined and by whom. QAI (2015: 9) maintains that, "special education classes and special schools send a powerful message of exclusion and play a role in setting many people with intellectual impairments on a descending life path" (also see Michael 2020).

Kelsey did not attend school past Year 1, when she was asked to leave because of violence against a teacher. The prison psychologist said that Kelsey's family life was chaotic, and when she was quite young, she was 'taken under the wing' of a family involved in crime, which became her way of life until she was 16. She was illiterate when she came to prison but has since completed some education courses. Amelia was also expelled during primary school, although she was reluctant to say why. She said that after that time, she remained at home and "just slept all day". Noelene liked primary school, although she hated the special school in which she was later enrolled because she was badly bullied. Several of the women, such as Georgina and Deidre, had very disrupted educational experiences because of foster care. Rosie was expelled from school at age 14 for arson attacks on the school.

For Erica, her longest period of sustained education occurred in juvenile detention. At the time of interview, she was the youngest person in the prison at 17 years of age and was attending

school most days. Jennifer was placed into juvenile detention at age 11, which represented the only education she received. Molly, who started petrol and glue sniffing by age nine, had only minimal experience of going to school. Mary, who gave birth at age 12, and Maddie, who had her first baby at 14, both had very limited time in school. Maddie was illiterate, although Mary, after spending many years cycling in and out of prison, has learned basic reading and writing skills. For the study's Indigenous participants, their limited experiences of education did not incorporate cultural knowledge. In fact, as the Prime Minister's *Closing the Gap* report (Commonwealth of Australia 2018: 57) states, "research indicates that classroom teachers devote less than five minutes per week to teaching Aboriginal and Torres Strait Islander curriculum, languages, literature and cultures, with many not engaged in these activities at all" (also see Luke et al. 2013).

These narratives present a particularly compelling picture of lack of inclusiveness in education. The presence of a cognitive disability contributed significantly to this lack of inclusivity, as did dysfunctional families in which the actions of family members, including substance abuse, resulted in little oversight of the women's education.

4.3.2 Formal networks: Employment outside

One of the issues identified by Bennett and Gallagher (2013) is the lack of supportive school-to-employment transitional planning, especially for those with cognitive disabilities, which exacerbates the problem of unemployment. An absence of people with cognitive disabilities in the workforce continues to be an area of exclusion regularly highlighted by advocacy groups and those who work and research in the disability sector (e.g., Hall 2017; McCarthy 2003; Redley 2009; QAI 2015; Winn and Hay 2009).

There is now broad recognition that solutions to women's offending lie outside the prison walls (Prison Reform Trust 2015) via jobs that enable them to obtain housing, care for their children and leave abusive relationships, making a return to crime less likely. However, the stigma of incarceration is pervasive, as several of the study's participants identified. Renata had a variety of part-time jobs while she was at school. She worked at McDonalds, a café, a chemist, a clothing store and completed a Technical and Further Education (TAFE) Certificate 3 in Aged Care. Prior to the accident that caused her ABI, she was employed as a charity worker. Renata said:

> I worked ever since I was in school. Some were shitty part-time jobs, but I had some money. Fat chance I'll ever get a job when I get out. As soon as people know you've been to prison, they can't get away fast enough. I want to be a beauty therapist. My

> friend has a salon and said she'll give me work. That's great – except for the criminal check.

Miriam, aged 68, was regularly employed in cleaning jobs prior to her incarceration. She said that from the age of 15 onwards, she had never had any long periods of unemployment, despite moving around the state frequently. She said, "By the time I get out of here, I'll be too old to work. No-one would want me anyway".

In most other cases, unemployment was intergenerational, particularly in families with substance abuse problems and family member incarceration. Jobs tended to be unskilled, low paid and mostly casual positions of short duration. Amelia worked part-time in a boarding kennel for dogs, feeding and grooming them. Noelene did some work experience in a butcher's shop restocking the fridges with drinks and helping with meat packaging. At the end of the day, the butcher would generally give her a meat pack as payment.

Theresa had a few casual jobs prior to prison. She did pamphlet delivery and worked on Hamilton Island in one of the hotel kitchens, where she was part of the food preparation and serving staff. She was there for about three months before relocating to live with an abusive partner. This is a situation that Hannah-Moffat and Innocente (2013) draw attention to, arguing that economic marginalisation often means that women are frequently pushed back into damaging partner relationships, which may be a facilitator for criminalised activities such as prostitution and drug dealing. Despite a range of initiatives developed to protect those with disabilities from unfair treatment, the fact remains that cognitively disabled women continue to face discrimination in trying to obtain work, more so if they have a mental health disorder (see Prince 2010; Vornholt et al. 2017). Most of the women in this study either gave up trying to get work or never even attempted to do so in the first place.

The women's narratives indicate that, like education, most of the women did not engage in employment. Cognitive disability was a contributing factor for several, as was a lack of formal education and/or job training.

4.3.3 Formal institutions: CPS

Chapter 2 discussed the deleterious effects that foster care can have on children and the way in which it contributes to social exclusion. As Kendrick (2009: 17) highlights, children and adolescents in foster care have already experienced an array of socially excluding forces with the experience of foster care intensifying social exclusion through "stigma, abusive practices and poor-quality care". Almost half of the women participating in this study were placed in

foster care. For each of them, foster care was a negative experience, and as the following stories illustrate, physical and sexual abuse and a general absence of oversight characterised the placements.

Noelene went straight into foster care after leaving school. Her siblings were also placed into care, although not in the same place as Noelene. She moved from foster home to foster home and was very unhappy in all of them. She said, “If they got sick of me they just moved me on”. Noelene said that there were generally five or six children in each of the homes. Alice was placed with CPS between the ages of 10-17. She continually ran away because she was unhappy. She attempted to return to her father, but because of his substance misuse and criminal record, unsupervised time with him was not permitted and she was either returned to the home or placed in a different one.

Georgina was surrendered by her parents to state care when she was 12 years old because of her challenging behaviours. Her parents were worried as she was becoming increasingly violent and they were fearful for their other children, including Georgina’s twin brother. This behaviour began after being sexually abused by her grandfather and her mother’s disbelief when Georgina told her. Georgina said that in the first house she was in, “the carers were not very good to me. They locked me in a room by myself for most of the time”. Shortly after her arrival in this house, two children with autism also came to live there, and they too were locked in separate rooms, where they would scream and bang on the doors and walls. Georgina said that she was placed in many different houses. “Some houses I was in had people who done stuff to me”. Georgina said that she damaged the houses mainly by punching holes in the walls. She also damaged the carers’ cars because “they were getting away with things”. She tried to tell CPS, but Georgina said that they would not help her. “They didn’t care”. Georgina remained in foster care until she aged out of the system. She was incarcerated at age 17, transitioning from foster care to prison.

There is considerable evidence to demonstrate that foster care arrangements for children with cognitive disabilities do not work and are in fact harmful (South Australian Office of the Guardian for Children and Young People 2020). Issues that are continually raised involve abuse in foster homes and lack of foster care options for high-needs children, such as those with cognitive disabilities and/or behavioural problems and mental health disorders (Lawrence et al. 2006). The combination of unstable foster home placements, frequent relocations, lack of attachment, chaotic environments and the absence of nurture are recognised as central to ongoing and entrenched disadvantage and social disconnection (Lee 2016). This was evidenced

by the women's narratives, which illustrated a range of harms experienced in foster care arrangements, including sexual abuse.

4.3.4 Formal institutions: CJS

The overrepresentation of cognitively disabled people in the CJS is directly linked to "lifelong exclusion, unemployment, poverty and limited community participation" (QAI 2015: 8). QAI (2015) also point out that cognitively disabled women in particular are likely to live in poverty, predisposing them to involvement in 'survival criminality' such as shoplifting. The following discussion considers the women's CJS involvement prior to incarceration, including interactions with police and legal representatives, juvenile detention and family incarceration, and the duality of the women as offenders and victims of domestic violence.

4.3.4.1 Police

Chapter 2 noted that as the police are the gatekeepers to the CJS, they are the first step towards the criminalisation of a person. Baldry (2018) highlights the problem of socially disadvantaged, cognitively disabled people who potentially become known to police because of challenging behaviours taking place in public spaces, often related to substance misuse, mental health disorders and homelessness (also see Lunsky et al. 2012; Raina and Lunsky 2010). Prison psychologists noted that difficulties in regulating challenging behaviours, remembering information, being able to concentrate for any length of time and being "highly suggestible" (Ochoa and Rome 2009: 133) were significant factors during police interviews. As French (2007) identifies, cognitively disabled people quite often say what they think the police want to hear and are more likely to confess to crimes because they believe this will please the police.

While this study involves Indigenous and non-Indigenous women, it is important to briefly examine the policing situation with respect to its Indigenous participants. McCausland et al. (2015) argue police are now most often first responders to Indigenous people with mental health disorders and cognitive disabilities. An absence of culturally sensitive community support and frequent interactions with police generates extensive and prolonged management by police and the CJS more generally. Indigenous communities are often over-policed, with significant sums of money spent on increasing the number of police cells, rather than investing in mental health and related community services (McCausland et al. 2015). Indigenous women are routinely apprehended for trivial offences, which often escalate to what is commonly referred to as 'the trifecta'—obscene language, resisting arrest and assaulting police (AHRC 2014: Ch. 6; ALRC 2018a: 11.64). The narratives of several of the study's Indigenous participants illustrated this fraught relationship. Belinda referred several times to the constant police presence in her

community and the issue of over-policing. She said, “I reckon there’s more of them than there is of us!” Alice was disparaging in comments about her interactions with police. She stated that they target her and she reacts to what she perceives as being “picked on”. She said, “I give them shit so they give me shit”. Melanie was particularly hostile when talking about police. She has been both a perpetrator and victim of domestic violence, but was upset that on several occasions the police arrested only her and not her partner, from whom she sustained several serious injuries. “The police are always on his side. They have a joke with him. They don’t even ask me whose fault it was”.

Jennifer had many interactions with police, most of which involved police physically restraining her, in both public spaces and in police cells. Jennifer fantasised about killing police officers. She was frightened of anyone in uniform, stemming from her belief that the police failed to keep her safe when she was young and living in an abusive environment. In the prison setting where uniforms are ever-present, her level of anxiousness was acute. Despite her love of animals, especially dogs, she was terrified of German Shepherds because it is the breed used by both the prison and the police.

Rosie disliked police intensely, based not only on her adult experiences of being targeted, but also a childhood experience involving her mother who was physically harmed by police. Rosie said, “They pulled her over and kneed her in the back. These were male coppers too. You don’t treat women like that”. Theresa remarked that over the course of her life the police have continually harassed her. Minor offences have seen her arrested many times. She called the police names, they challenged her, she pushed back physically and was then charged with assaulting police and resisting arrest. However, Theresa did not refer to disliking the police. Her comment was related to changing herself by “getting my brain to say ‘no’. I want to train my brain to think first”. Three of the study’s Indigenous women (Melanie, Rosie and Susan) referred to the tragic case of Ms Dhu, who died in police custody in South Hedland, Western Australia, in 2014. They were emotional in talking about a situation which they said caused much anger in Indigenous communities. All three stated they ‘hate police’ but were also scared of them. Rosie said, “That could of been me. There’s no reason it couldn’t. I’m black. I’m a woman. I was in the cells when I was on ice. I was going crazy”.

Lack of eye-to-eye contact in tandem with language barriers was also problematic for several of the study’s Indigenous women. According to the prison ODM, these factors were evident at every stage of Caroline’s passage through the CJS. Caroline was substance-affected during police interviews, further undermining her ability to not only comprehend what was said/asked, but to understand that she had broken the law and the consequences of that. The ALO who

worked with Sally also drew attention to the challenges she faced because of poor language and comprehension. She was in prison for assaulting a police officer, but throughout her interview was confused as to why she was there. She was unable to comprehend why the police arrested her when she said 'sorry' to them. In her mind, an apology should have been an end to the matter.

While the study's non-Indigenous participants referred to police negatively, the concern about over-policing was less obvious. Several reported having been given a police caution prior to being arrested. However, they still believed that being 'known' to police made them targets for future interventions. During her interview, Erica said several times that "the coppers pick on me" also saying that because of this, "I'll probably come back here [prison]". Bronwyn had mixed reactions when interacting with the police. She said that there were "some mean ones". Bronwyn commented, "most of the time the police don't tell me why I'm being arrested". In speaking with the prison psychologist, it was pointed out that the police inform Bronwyn of the charges and why they are arresting her, but much of the time she does not understand what they are saying, particularly in relation to her rights. She was also very violent towards the police when they apprehended her.

French (2007) argues that unsuitable or inappropriate policing practices, based on flawed beliefs that those with cognitive disabilities are more prone to crime, see them caught up in the CJS as suspects, defendants and convicted offenders. Over the course of interviews with the women, it was evident that several of them had a 'profile' that saw them regularly apprehended, exacerbating poor relations between them and the police. This is a process that begins with the unequal treatment of (generally marginalised) people by authority figures such as the police "initiates a dynamic process which exacerbates social exclusion" (Emler and Reicher 2004: 229). In general, the women's experiences with police interactions were negative, with issues of both over- and under-policing cited as problematic by the study's Indigenous participants. Being 'known' to police led several participants to conclude that the police specifically targeted them.

4.3.4.2 Juvenile detention

Chapter 2 highlighted the factors commonly associated with young people who serve time in juvenile detention: established disadvantage, low education, substance misuse, unstable living arrangements, histories of abuse and time spent in state care (Cunneen et al. 2016). Juvenile detention was predominantly a negative experience for study participants, marked by a culture of bullying by other detainees and correctional staff. The following examples highlight the

‘detention to prison’ pipeline, with each of the women transitioning almost immediately from a juvenile facility to adult prison.

Jennifer had her first encounter with the CJS as a juvenile who ran away from home to escape a highly abusive situation. Jennifer was in juvenile detention from age 11 until she transitioned to an adult facility. She has had only one birthday in her community since the age of 11, with all other birthdays spent in either juvenile detention or prison. Rachel was a little older than Jennifer when she went to juvenile detention at age 15. She participated in education while in detention, but said that she was bullied by staff and other detainees. Rachel’s fire-setting was the reason she was sent to a juvenile facility. It is apparent this issue was not resolved by placing her there, as subsequent fire-setting resulted in her incarceration in an adult facility and was a focus of therapeutic interventions by the prison psychologist. Noelene’s offending history commenced in 1995 when she was 15 and included convictions for assaulting police and the serious assault of a person she was attempting to rob. She was committed to juvenile detention, released in 1997, but reoffended almost immediately and was reincarcerated in an adult facility. She said, “I was bullied there. I hated it”.

Erica’s experience of juvenile detention was different to that of the other women. It represented Foucauldianand participate in sporting activities such as swimming in the pool. The prison psychologist noted that the time spent in a juvenile facility was the most sustained period of education for Erica and was also a time in which she felt safe and secure. She talked about her happiest day being when her mother came to visit her in juvenile detention and brought her a cake for her sixteenth birthday. Erica transitioned immediately from juvenile detention to prison.

A critical issue associated with time spent in a juvenile facility is the effect it has on self-identity, particularly if there are multiple or sustained periods of detention. (Baldry and Dowse 2013). As Emler and Reicher (2004) argue, once a young person feels rejected by ‘the law’ or ‘the system’, they begin to view themselves as ‘outlaws’.

This is reflected in the narratives of the women in this study, whereby the construction of ‘the problem’ holds them entirely responsible for their offending, while simultaneously deflecting attention away from issues of poverty, unemployment and racism, and matters of social inequality (White and Cunneen 2015). Disability and mental illness are sometimes unsatisfactorily identified in the youth justice system, which has implications for the way that cognitively disabled youth are responded to by those interacting with them (Mitchell 2017). Unacknowledged cognitive disability or mental illness means that appropriate supports may not

be put in place, resulting in discrimination throughout youth justice processes. Retributive responses that see young people placed in juvenile facilities do nothing to reduce rates of reoffending, and various authors point out that offending rates may actually increase (e.g., Halsey 2008; White and Cunneen 2015). As Emler and Reicher (2004) stress, punitive interventions for young people serve only to make temporary forms of exclusion more permanent.

4.3.4.3 Court processes

Court was a fraught experience for this group of women. In several cases, past experiences of court were sufficient to convince them that turning up to their court date was not a good idea and so they failed to appear, adding yet another charge to the list. Women who were homeless or residing in unstable living arrangements often did not receive notifications regarding their charges and court appearances. For example, the prison psychologist said that prior to her incarceration, Ruth mostly stayed in a camp for homeless people that was quite a long way from town, making it unlikely that she received notifications of impending court dates. Court appearances were primarily related to Ruth's inability to meet weekly with her parole officer because of the distance she had to walk to get there. Consequently, failure to appear at either venue (parole office or court) saw her returned to prison. Several of the women said that they could not understand why they were in prison because nobody had told them that they had to go to court.

In Caroline's case, the prison ODM expressed amazement that Caroline was deemed capable to stand trial, given that the presence of a cognitive disability was unmistakable and her understanding of court processes negligible. Caroline was substance-affected during police interviews, with minimal capacity to make rational choices and/or decisions, calling into question the premise of 'fit to plead'. Prior to the court appearance that resulted in her current (at the time of interview) custodial sentence, Caroline spent four months in a secure mental health facility. At the time she was sent to prison, she was receiving pharmacological interventions for ongoing mental health issues, significantly impacting her ability to comprehend legal processes. In the view of the ODM and ALO, the presumption that she was cognisant of the legal aspects of her case, the nature of her crimes and the intent to commit them was inexplicable.

Alice was very upset by her experiences of going to court. She said that she was kept in the watch-house because the police told her it would not be appropriate to take her up into the courtroom because of "how I was". According to the prison counsellor, Alice had no legal

support, nor did she have an advocate to help her. Alice said, “I was yelling, ‘Tell me what’s happening’ but no-one came. That’s why they wouldn’t let me up there, because I was yelling”. Similarly, Molly had no comprehension about why she was in prison and the events leading up to her incarceration. She said, “I’ve been locked away because I didn’t go to court”. She was adamant that the court date was meant to be several days after the scheduled time and that she did not get it wrong, the police did. According to the prison psychologist, Molly was confused about when she had to go to court and did not turn up for her scheduled hearing. However, the psychologist also pointed out that because of her significant mental health and substance misuse disorders, Molly could not possibly attend court without a support person to help her. At the time of interview, Molly was bewildered and agitated, raising the question of the feasibility of court attendance. Bronwyn had a lawyer who went to court with her and who “kind of explained it, but I didn’t really get it”. The lawyer managed to secure bail for her on several occasions. However, even with a supportive lawyer, lack of inter-agency communication resulted in a less than happy ending (see ‘Bronwyn’s story’ in Appendix 6).

Grunseit et al. (2008) draw attention to the fact that prisoners are not always able to see a lawyer before attending court, nor can they be confident a lawyer will be present when their court appearance is scheduled. It is often the case that any legal visits taking place prior to appearing in the court room are generally of short duration, which does not bode well for those with cognitive disabilities who may require more time in which to have processes properly explained. Gray et al. (2009: 8) maintain that, “for people with an intellectual disability who must appear in court, oftentimes charged with a criminal offence, the experience can range from bewildering to terrifying”. Additionally, proceedings that are lengthy and/or have long wait times during and between court hearings are particularly stressful, as are time lapses between when the person is arrested and when they finally go to court.

The women’s narratives all reflected a key word, ‘confusion’. Court processes relying on written communication providing instructions about attendance were either not received because the women were homeless, or disregarded because they did not understand them. Experiences of court were referred to negatively, mostly because of little understanding of the processes involved.

4.3.4.4 Family and partner incarceration

A further consideration is the significance of relationships and the role of family members and partners in modelling and/or encouraging criminal involvement (Chesney-Lind 1997; Owen and Bloom 1995; Owen 1998; Pollock 1998). As several of the women in this study

demonstrate, the experience of partner, family member and intergenerational incarceration is not uncommon, with family and partner incarceration impacting a number of the women in this study. At the time of interview, Rosie's mother, Kelsey's father and Maddie's father were in prison. In considering Figure 2, key takeaways are first, that at the time of interview, of the 23 study participants, 14 had family members and/or partners who were simultaneously incarcerated. Second, three of the 14 participants had more than one family member incarcerated at this time.

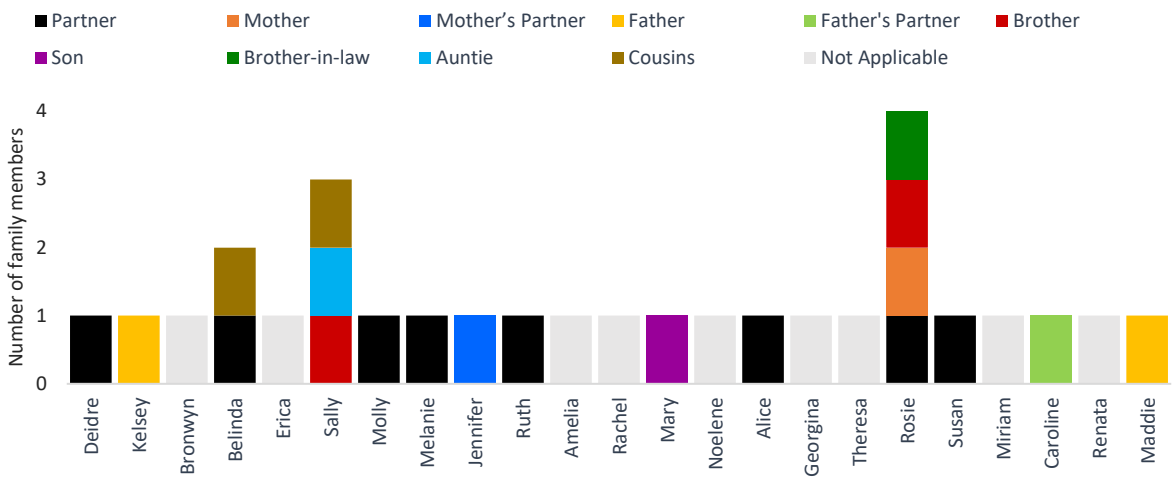


Figure 2: Family incarceration by participant

Several members of Sally's family were incarcerated at the same time as Sally. Her (male) cousin was serving a 25-year sentence for murder. Another cousin was also serving a 25-year sentence for murdering their partner, and she, along with Sally's aunt, were incarcerated in the same prison as Sally. Violence and assault, mostly related to substance use, were the main reasons for their imprisonment. Likewise, Melanie and Belinda were impacted by intergenerational and family incarceration arising out of circumstances similar to Sally's. Both Melanie and Belinda's partners (also fathers to their children) were ice addicts, incarcerated at the same time as Melanie and Belinda for drug-related violent offending.

Kelsey's father was serving a 25-year sentence for murder. Kelsey was only 12 when a friend of her father's raped her. Kelsey said, "That's why my dad's in gaol. He killed him". At the time of interview, several members of Theresa's family were also incarcerated, including a male cousin serving a 25-year sentence for murder. Maddie's parents have both been incarcerated on several occasions. Her father was in prison for domestic violence offences and drug possession, serving a sentence at the same time as Maddie.

Alice's sister was incarcerated in the same prison as Alice but was released four weeks prior to Alice's interview. Rosie lived mostly in foster care and with her grandmother, as her mother continuously cycled in and out of prison. Both her mother and brother were addicted to ice and heroin, the cause of multiple custodial episodes. Her sister and her sister's partner were also ice addicts, incarcerated on numerous occasions. At the time of interview, Rosie's sister's partner was serving a four-year sentence for drug-related offences.

Various scholars note the correlates between intergenerational incarceration and intergenerational social exclusion (e.g., Besemer and Dennison 2019; Cochran et al. 2018; Foster and Hagan 2007, 2015; Murray 2007; Ng et al. 2013; Salisbury and Van Voorhis). Foster and Hagan (2007) argue that problems with children's socialisation as a result of parental incarceration, as well as heightened risk of juvenile detention, are central to the cumulative process of disadvantage. The term 'packages of risk' is employed by Giordano and Copp (2015) to describe the outcomes of family incarceration exacerbating pre-existing social exclusion.

The women's narratives highlighted an important consideration, the fact that for those who had incarcerated family members, incarceration was nothing out of the ordinary. In fact, women who were co-incarcerated with family members were happy about this as it kept them together as a family. While this potentially contributed to social exclusion outside the prison, inside the prison it provided a sense of 'belonging'.

4.3.4.5 Victim-offender nexus

Bartels and Easteal (2016: 2017) argue that ""there has traditionally been a tendency to see victims and offenders as two discrete groups, with the result that those who engage in risky or dangerous behaviour are excluded from our conceptualisation of those who require protection"" (also see Gilson 2013; Taylor et. al. 2013). Research by Brewer-Smyth discovered that women convicted of violent crimes had "significantly higher childhood physical and sexual abuse and more recent abuse perpetrated against them than those convicted of non-violent crimes" (2004: 837). In terms of this study, the vulnerability of women with cognitive disabilities to situations of domestic violence was conspicuous. In many instances, they witnessed domestic violence as children, with their own situations reflective of this interpersonal violence.

Figure 3 illustrates the nexus between the women as victims and offenders in situations of partner violence. Twelve study participants served custodial sentences for domestic violence offences and for breaching domestic violence orders (DVOs). Three women were officially recorded as being both a victim and perpetrator of domestic. A further two women participants were victims of domestic violence. While a DVO is a legally authorised sanction against the

women, they lack a moral perspective that considers the issue of provocation and the women's self-protective mechanisms (Ballan and Freyer 2012).

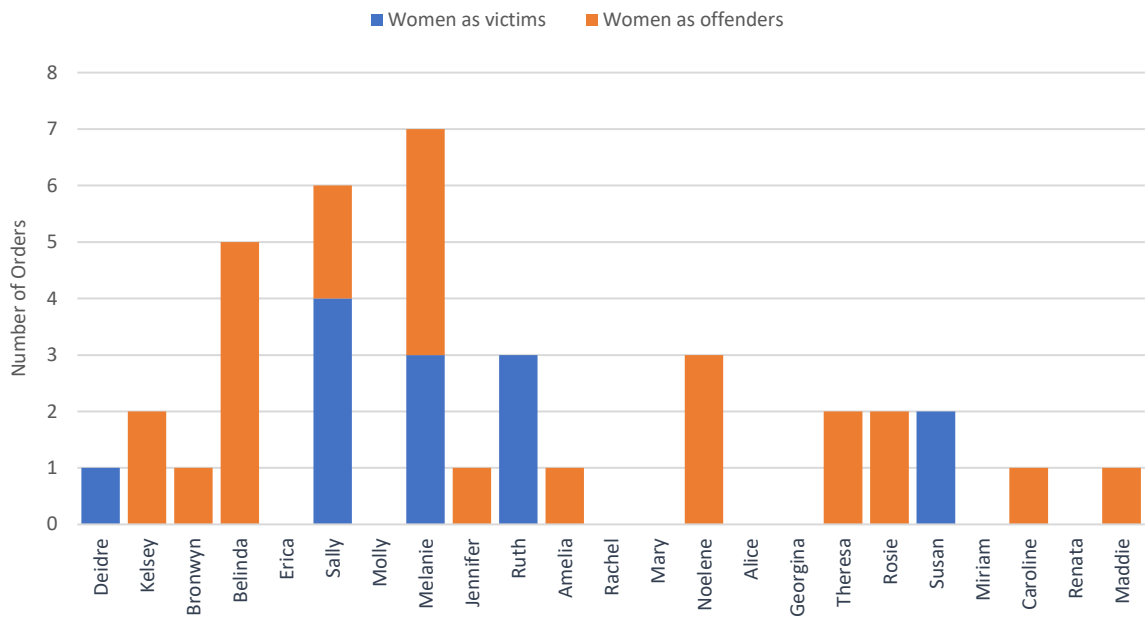


Figure 3: Breaches of domestic violence orders by and against participants

Melanie spoke about the DVOs issued against her by her partner. She said, "I hit him with a closed fist twice in the face. He called out to the neighbours to ring the cops. When the cops came they just put me straight in the paddy-wagon, then I went straight into the watch-house then straight to prison". At the time of interview, Melanie was serving a sentence for holding a knife to her partner's throat while intoxicated. However, she said that she had been arrested on occasions when the police were summoned because of violence against her, but she was the one removed by police while her partner was given a verbal warning. Belinda was also incarcerated for a violent act against her (violent) partner. In reference to this she said, "I sliced him up real good".

Rosie was in an extremely violent relationship with the father of her seven-year-old child. He repeatedly struck Rosie and told her he wanted to "kill the little bastard" when Rosie told him she was pregnant. He encouraged her to have a termination. Ruth was also in a violent, abusive relationship in which both she and her partner were at various times arrested, charged and convicted. Ruth eventually ran away, ending up homeless. At the time of interview, she was pregnant, and according to the prison psychologist, her partner rang the prison often and abused

the staff, saying that he wanted to take Ruth's child when it was born. He was not interested in a relationship with Ruth and told staff that he did not care what happened to her.

Various organisations (e.g., ADCQ 2019; QAI 2015; WWDA 2007) point to the high representation of women with cognitive disabilities who are implicated in cases of domestic violence. However, as they also maintain, family violence involving women with cognitive disabilities is inextricably linked to social exclusion. The ripple effects of violence, such as poor mental health and substance abuse, not only contribute to social exclusion, they are socially exclusive forces themselves. The women's narratives emphasise the impact of these factors. In the case of the study's Indigenous women, policing inconsistencies that led to their arrest in situations of two-way violence was an issue of injustice they found concerning.

4.4 Domain 3: Trust and safety on the outside

Because of the absence of a trusting relationship with parents and family members, and interactions with formal institutions such as CPS and the CJS, 'feeling unsafe' permeated many of the women's narratives. Throughout the women's stories, the sense of sadness was amplified by an immutable factor, cognitive disability. Their dependence on the adults in their lives to provide safety and guidance, which for the most part was absent, heightened their vulnerability, and this did not subside as they aged. As the following narratives illustrate, if anything, the level of vulnerability increased, with women such as Caroline, Maddie and Mary giving birth while they were little more than children themselves. Domain 3 examines issues of trust and safety pertaining to key themes of family, trauma, CPS involvement, peers and interactions with the CJS. Connections with Domains 1 and 2 are evident, with related indicators such as family, friends, police and legal representation providing further insight into a domain of social exclusion that remains somewhat under-acknowledged (Hayes et al. 2008; LaBonte et al. 2011).

4.4.1 Trust and family

Crewe et al. (2017) argue that childhood sexual and physical abuse is a betrayal of trust that erodes the notion of 'family' as a safe environment (also see Etherington 2008; Stenius and Veysey 2005). Challenges associated with avoiding coercion within these relationships, which may be significant when a high degree of dependency is involved, is problematic, especially if that person is relying on family members to manage safety matters in other environments, such as school or community where coercion may have broader safety repercussions (Briggs and Hawkins 2005; Khemka et al. 2009; Robinson 2015).

The majority of the study's participants experienced volatile family relationships, meaning that being safe at home was not a common experience. Abuse, neglect and harm, in the form of childhood abuse, sexual assault and domestic violence, profoundly affected the women's safety and wellbeing. Vangelisti et al. (2007: 357) highlight the nature of hurtful family environments that are characterised by "aggression, lack of affection, neglect, and violence". This was evidenced in this study by relationships such as Susan's, whose mother was inherently cruel both physically and emotionally, constantly telling Susan she should "go off and die", and Mary's mother, who openly disliked Mary from a very early age, offering no protection or support when Mary became pregnant at age 11. For women like Belinda, Sally, Maddie and Ruth, safety within the family environment was not their 'norm', with family members responsible for unsafe situations. Lack of healthy support networks characterised the lives of many of the study participants.

The discussion of trauma in Domain 1 (informal networks outside prison) aligns closely with issues of trust and safety. "Betrayal trauma" (Gobin and Freyd 2014: 505) is associated with innumerable long-term consequences, for example, mental health disorders and long-term trust issues (Hunziker 2014). Gobin and Freyd (2014: 505) maintain that, "the few investigations that exist in this area have shown that early betrayal trauma results in high levels of distrust". Rosie was emotional when she spoke about the betrayal of trust by her mother. Rosie said, "She did her dash with me. Two weeks before I had my baby, she left. She said, 'I'll be back' but she went out the door and never came back. She was there for my sister's baby's birth, but not for me". As a child and teenager, Susan's mother constantly told her that she (her mother) loved her younger brother and sister more. Her mother was very violent, especially towards Susan who said that as children they were smacked, but "my mum flogged the crap out of me".

Zurbriggen and Freyd (2004) argue that traumatic betrayals impair cognitive processes that allow people to appropriately assess the trustworthiness of another, potentially leading to trust being placed in unreliable persons, thus escalating the danger of additional abuse. This was exemplified throughout several of the women's narratives, in which they repeatedly substituted one untrustworthy person for another. Amelia, who ran away from a highly abusive partner, ended up with multiple sexual substitutes who systematically used and discarded her. Caroline, with a pronounced cognitive disability, was a frequent victim of misplaced trust, beginning with her abusive and drug-affected parents, before moving to her drug-affected grandmother, the only person who would take her in. The impact of Caroline's and Amelia's narratives was intensified by a naiveté and bewilderment about the way in which those entrusted with their care had failed them so miserably. As Twenge et al. (2007: 63) contend, betrayals of trust are

linked with social exclusion in that "the socially excluded person seems to adopt an attitude best characterised as wary" (also see Bridges 2003). Discussions of trust in the context of family elicited revelations from the women that raised the question of whether they would ever have the capacity to trust anyone in their lives, particularly in cases where their trust in parents was so completely undermined.

4.4.2 Trust and peers

Witnessing peer violence and experiencing bullying and interpersonal abuse was a common theme running through many of the women's narratives. None of the women reported having a close friend or confidante they trusted. Most peer associations centred on an imbalanced relationship in which the women were taken advantage of or coerced into antisocial or criminal behaviour. Several women, such as Bronwyn and Renata, spoke about teachers they had a school who they felt could be trusted and with whom they felt safe. Upon asking Susan about anyone she trusted, she initially said there was no-one, but then thought further and said there was a teacher in high school who supported and helped her in the Special Education Unit. Susan recounted an incident where her mother took her and her sister to a Vanessa Amorosi concert. Susan said it was one of the best nights of her life, but when they got into the venue, there were crowds of people and she became separated from her mother and sister. She could not believe it when she looked up and saw her favourite teacher there. The teacher came and collected Susan, they watched the concert together, then later, with the help of security, they found Susan's mother. Notwithstanding this example, the women expressed a lack of trust in teachers, primarily due to the fact that when they confided in their teacher that they were being bullied, no action was taken. Caroline, Maddie, Noelene and Rachel all reported a lack of concern by teachers in relation to peer bullying,

Bourke and Burgman (2010), Cummings et al. (2006) and Briggs and Hawkins (2005) highlight safety issues related to bullying, noting that children with cognitive disabilities experience more bullying than those without disability, regardless of age or gender (also see Prince and Hadwin 2013). As women such as Georgina, Noelene, Deidre and Theresa identified, they expected to be bullied by peers at school, referring to themselves as "easy targets". Briggs and Hawkins (2005) argue that this is linked to a wider context in which cognitively disabled children and young people may be viewed as 'safe targets' because there is the perception that they will be less likely to report the bullying, as well as being less perceptive about behaviour that is appropriate/inappropriate.

With the exception of Susan's favourite teacher, none of the women experienced a trusting relationship with peers or other adults outside the family. Relationships were based on coercion, not on trust, with the women often taken advantage of by uncaring peers.

4.4.3 Trust and the CPS

Robinson et al. (2017: 17) maintain that "young people with disability who come into contact with systemic settings that imply particular vulnerability or complex needs, may experience safety considerations at a heightened level. For example, for young people with disability in child protection, maintaining voice, communication and rights are key safety and self-advocacy considerations" (also see Flynn 2019; Flynn and McGregor 2017). Robinson et al. (2017) highlight the lack of accountability in many care arrangements, with poor or very limited reporting of concerns raised by cognitively disabled young people. This absence of trust in foster care arrangements has been the subject of scholarly attention, with researchers identifying the lack of connection between foster parents and children as the main reason for this situation (Catalano and Kellog 2020; Storer et al. 2014; Vanderwill et al. 2020).

Rosie and her siblings were taken by CPS because their mother was in and out of prison. However, when Rosie's mother was released, she fought for custody of Rosie's brother and sister, who were returned to her. Rosie said she was deeply hurt by this and could not understand why her mother did not fight for her as well. Rosie remained in foster care until she was 16 which she said, "…sucked. They couldn't care less about us, not even if we had proper food. I hated every minute of it". As Blakely et al. (2017) maintain, young people who may be forced to stay in difficult or abusive foster care settings because of their age and the fact that they have nowhere else to go are particularly vulnerable. For them, foster care is a time of risk, as they are again deprived of a home that is safe (also see Robinson et al. 2017).

Trust in the CPS and 'feeling safe' were absent for the women placed in foster care, also highlighted in Domain 2 (formal networks on the outside). In listening to the women speak of this, the overriding question was "how will they ever be able to trust anyone"? From family situations minus trust, to foster care in which trust was eroded further, it was clear that notions of 'trust' were shaped by a series of experiences from which recovery might never happen.

4.4.4 Trust and the CJS

Bullying by staff and detainees in juvenile facilities impacted feelings of trust and safety for several of the women detained there. Rachel and Noelene experienced high levels of bullying while in juvenile detention and said that most of the time they were frightened. Information

from the prison psychologist revealed that for Noelene, who was also abused while in foster care, the erosion of trust in adults assigned to her care has manifested as unpredictable violence. As various scholars argue, young people with cognitive disabilities and high support needs who go to juvenile detention have little or no control over what is happening to them, nor are they likely to access information about processes and protocols designed to keep them safe (Moore et al. 2015; Moore and McArthur 2017; Robinson 2015).

In general, trust in the police was minimal, especially for women who were victims of domestic violence, where police inaction in response to family violence was highlighted by several women such as Melanie and Belinda. There was also minimal evidence of trust between the study's participants and CJS agents. This was based on factors such as legal representatives who spent the shortest amount of time possible explaining court procedures, legal representatives who did not explain anything at all, legal representatives who failed to turn up for court appearances, judges who did not talk to them and lack of trust in court processes brought about by continual delays in having their matter heard.

4.4.5 Reciprocity of trust

The reciprocity of trust and safety also came to light during the women's interviews. Miriam has had no contact with any of her three children for over 20 years. Her crimes pertained to the sexual abuse of her children over a number of years. Deidre too was incarcerated for the sexual abuse of her children (see 'Deidre's story' in Appendix 7). Although Deidre's offending was coerced, her children were too young at the time to comprehend this and have not wanted to reconnect with her. The two women's notions of 'trust and safety' were quite disparate. In discussing matters of trust and safety, Deidre openly addressed the matter of what she did to her children and said she knew that because of her actions they would never trust her again. While she spoke about her lack of trust and complete absence of 'feeling safe' in relation to almost everyone in her life from early childhood onwards, reflective of Gobin and Freyd's (2014) 'betrayal trauma', she also took responsibility for destroying the trust of her children. Conversely, Miriam's conversation about trust and safety was one-directional, in which she referred constantly to how there was no-one she could trust, saying that, "I don't trust nobody, not here [prison], not outside". She made no reference to her children, except to say that she was no longer in contact with any of them.

Community trust and feelings of 'being safe' was also absent for most of the women. For Belinda, Sally and Melanie, community factors, such as the area's colonial history and dispossession and lack of employment, resources and opportunities for participation, played a

role in undermining "relationships of trust; norms of cooperation and reciprocity; patterns of mutual aid and information exchange, and perceptions of safety" (Cattell 2001: 1512). What was most noticeable among the women, however, was the absence of community services providing safe accommodation or general advocacy and support.

Despite known factors such as high rates of poly-drug and alcohol use, mental health disorders and cognitive disabilities, none of the women who had been in and out of prison over a number of years had ever received community-based help.

4.5 Domain 4: Health and wellbeing on the outside

The relationship between 'social exclusion' and 'health', particularly as it relates to the cognitively disabled women in this study, is underpinned by connections between health and wellbeing, poverty, trauma, substance abuse and community disconnection. As Domain 4 identifies, many of the mechanisms leading to and perpetuating poor physical and mental health are related to social exclusion commencing in childhood. Cognitively disabled women are particularly vulnerable when it comes to accessing health services, especially if they are reliant on someone else to facilitate the process. Cognitive disability also continues to shape medical attitudes towards impaired women because they are not viewed as capable of rational input into their own health matters (Howe 2009; Taggart et al. 2010). Over and above substance misuse, which significantly impacts mental and physical health, the women's overall poor physical health was attributed to smoking, unsafe sexual practices, poor diet and lack engagement with health clinics and practitioners.

4.5.1 Health and substance misuse

Chapter 2 presented the theoretical contributions of Buchanan (2004) in which he links substance misuse with social exclusion. Buchanan maintains that substance use is shaped by disadvantaged circumstances and social exclusion, conditions that tend to precede substance use itself. However, it is also clear that the reverse is true; substance misuse contributes to social exclusion, especially when substance use and associated antisocial behaviour occur in public spaces.

It was apparent when speaking with the women in this study that initial substance use was often due to the imitation of family members. Peer group pressure was also a significant factor, not only for substance use itself, but also for related offending such as stealing. Substance use, as well as substance-related offending in public spaces (e.g., failing to dispose of needles appropriately), often led to police interventions. Substance-driven challenging behaviours in

public spaces (e.g., offensive language and/or assaults) also attracted public and police attention.

Figure 4 presents several important considerations. First, according to prison practitioners, and as self-reported by the women, substance misuse affected all but one of the study's participants. Second, the age range in which substance use commenced indicates that for the majority of the women this was between five and 14 years of age. Third, most of the women used more than one substance, generally illicit drugs and alcohol. Three women used three different substances, a combination of drugs and alcohol, along with glue, paint or petrol sniffing that began in childhood.

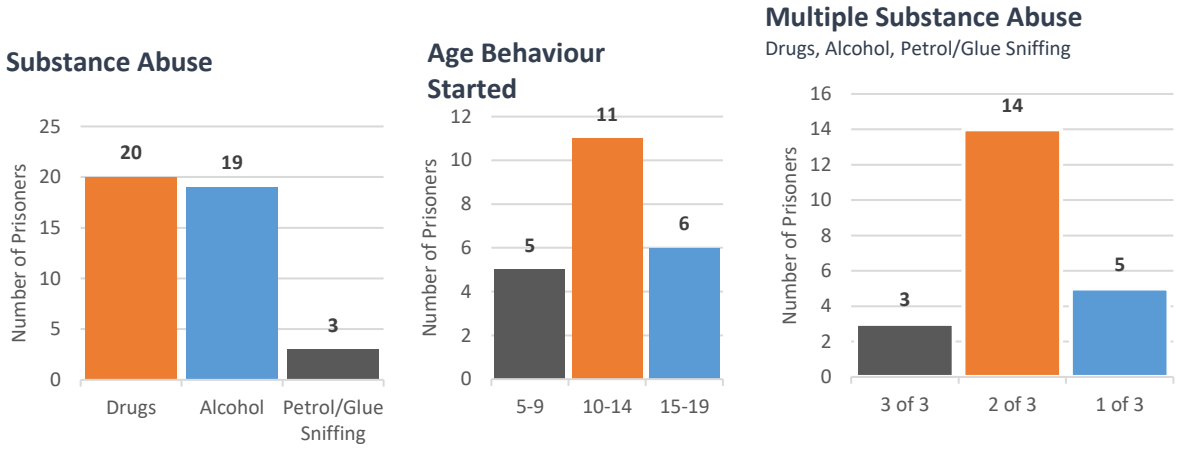


Figure 4: Participants' substance abuse

Rosie said that her mother, brother and sister were addicted to ice. Rosie was "curious about ice", began using and became dependent. She used ice every day for four years and it was hugely expensive. "It stuffed me up. I don't sleep properly. I can't have a proper conversation". Rosie felt that depression was a major contributor to drug-taking. She did not see a doctor about her depression, instead self-medicating using ice. While Bronwyn was not a drug user, she was a heavy alcohol consumer. She said, "When I'm not in prison, I drink a lot". She commented that when she drinks, she ends up feeling angry and depressed. She can feel the change happening and makes a promise not to drink any more, but then, "I wake up and think 'What the fuck' and I start all over again".

According to the prison psychologist, Sally began drinking alcohol and smoking cannabis at age 10. She had several convictions for assault of a police officer, committed while under the influence of drugs and alcohol. Alcohol in Sally's community is managed via a canteen arrangement administered by the state government, and although not a 'dry' community as such, alcohol monitoring takes place. Like Sally, most of Caroline's offending took place when

she was on drugs. The ODM stated that Caroline's substance abuse began at age 15 when she became addicted to Valium and methamphetamines. She was also drinking a bottle of spirits every day. Caroline's mother was an alcoholic and drug addict. Her grandmother, who was her key support, was also drug addicted. The ODM spoke about Maddie, whose parents were both addicted to ice and heroin. Maddie began using drugs at age 12. She exchanged sexual favours for drugs, leading to the birth of her first child at age 14. Similarly, Belinda's family all used drugs and alcohol and Belinda grew up witnessing this. The prison psychologist revealed that Belinda was first arrested at age 13 for violent crimes committed under the influence of drugs and alcohol. Belinda said that when she is not in prison, she used marijuana often. Her idea of post-prison life was to return to her community and "have a drink and a joint".

The prison psychologist stated that Molly started petrol and paint sniffing at age eight, which caused her cognitive impairment. The ALO commented that Molly has had lifelong problems with substance abuse. At the time of interview, she was on a prison-administered drug regime, which was closely monitored because of her pregnancy. Like Molly, the psychologist identified that Melanie's cognitive impairment occurred through glue and paint sniffing from age eight until age 15. Ruth, also pregnant at the time of interview, had a history of chronic substance abuse. Prior to her incarceration, she suffered from drug-induced psychotic episodes which the psychologist said were managed in prison via a drug regime.

A prison counsellor said that Mary began using drugs and alcohol by the time she was 10, introduced to substances by an older sister. She started using methamphetamines at age 15 and has been unable to stop when she is out of prison. Heroin has been the main drug in her life, an expensive habit that led to stealing. Alice also had a chronic substance abuse problem and smoked cannabis from a very young age. Alice said, "I also used ice and it was a really bad experience. Being on it was ok but coming off it was terrible". She went on to say, "I was an arsehole [when I was on ice]. You don't realise how it affects the people around you". When asked what contributed to her offending, Alice said, "It's mostly who I hang around with. Also the drugs. When you're on the drugs you don't give a shit. Same as on the alcohol".

Alice's point regarding "who I hang around with" is something acknowledged by a variety of authors. The desire to 'fit in', increase inclusion and overcome loneliness and stigmatisation is often the motivation behind the use of substances by people with cognitive disabilities (see Chapman and Wu 2012; Degenhardt 2000). However, rather than boosting social inclusion, substance use that fosters challenging behaviours in public spaces most often invokes social distancing and condemnation (England 2008).

The women's narratives highlight the deleterious effects of substance misuse, but also the inevitability for several of them for substance abuse to be part of their lives. From childhood exposure to peers encouraging substance use, the vulnerability associated with their cognitive disability was central to substance misuse.

4.5.2 Health and mental disorders

Women with cognitive disabilities are more vulnerable to mental health problems (Lunsky and Havercamp 2002), often due to social and economic disadvantage, along with their vulnerability to abuse and violence. The mental health of the women in the study was impacted by many of the factors discussed thus far: trauma and abuse, grief and loss, and substance abuse. For women such as Mary, Molly, Sally, Melanie, Belinda and Maddie, whose substance abuse began in childhood, mental health problems manifested early on. The prison psychologist said that Ruth, whose traumatic history of sexual abuse began before the age of eight, experienced drug-induced psychotic-based mental health issues. She was diagnosed with schizophrenia in her late teens, as was Belinda. Belinda was on a Mental Health Tribunal Treatment Order, but the ALO said that she was non-compliant when in the community, something addressed by the prison where she received fortnightly injections.

According to the prison ALO, Caroline was committed to a secure mental health facility at various times, with her most recent episode lasting four months. She went straight from the secure mental health hospital to prison, where her chronic depression was treated pharmacologically. Bronwyn said that her poor mental health was a result of alcohol, and while she knew what it was doing to her, she has been unable to stop drinking when not in prison. Kinner et al. (2012) highlight this concern, identifying the fact that those who exit prison commonly return to previous patterns of behaviour, which is often the reason for reoffending and reincarceration (also see Kinner and Wang 2014).

Mary suffered from a mood disorder. She was only 12 when she had her first child and she struggled to cope. She said, "The baby cried and cried. I put the pillow over his face once, but never again". She recalled feeling overwhelmed and depressed, and almost immediately resumed her drug habit. Her partner has never used drugs, and he and his mother were Mary's main supports during this time. Noelene has Borderline Personality Disorder (BPD) and Susan has been diagnosed with Bipolar Disorder (BD). Despite her formal diagnosis, Susan's mother refused to obtain the recommended medications for her. Her condition escalated and was chronic during the years when she was homeless. She received medication in prison, which stabilised her.

All the women involved in this study suffered from one or more mental health disorders, most of which were present pre-incarceration. In most cases, mental health was closely associated with substance abuse. However, with the exception of Belinda, none of the women had ever received help with mental health when they were in the community.

4.5.3 Health and physical disorders

Lower levels of health knowledge and participation in screening for certain conditions meant that for the women in this study, treatment was often delayed or non-existent. Many of them lived at the margins of society, often with unhealthy lifestyles including addictions such as alcohol, smoking and drug use (Van den Bergh et al. 2011). Link et al. (2018) highlight the close connection between poor physical health and its contribution to compromised mental health such as depression. Most women had no contact, or only limited contact, with community health services. Various authors argue that the physical health needs of women entering prison has the potential to eclipse other correctional concerns, including mental health (Harner and Riley 2013; Van den Bergh et al. 2009).

When asked about their physical health, a number of the women spoke negatively about the state of their health outside prison. Several, like Melanie, Theresa, Amelia and Deidre, talked of headaches and stomach complaints. Sexually risky behaviours resulted in several of the women contracting sexually transmitted infections (STIs) such as chlamydia, gonorrhoea and syphilis, which mostly remained untreated prior to prison. Noelene and Maddie both entered prison with STIs. Some reported chronic pelvic pain due to these conditions, but did not seek medical help. Rosie said, “I just hoped it’d go away by itself”. Information about the women’s STIs prior to prison was provided by prison practitioners.

Several of the study’s Indigenous participants were previously clients of community Indigenous health centres and had been treated for smoking-related conditions such as asthma, as well as STIs. Prior to prison, Melanie did not have a regular doctor, but used the Indigenous clinic from time to time. Alice was helped by her Indigenous health clinic to give up smoking and felt that her health improved as a result of this. Most of the Indigenous women commented that they hoped to connect with their Indigenous health centres when they exited prison. Theresa said that her community health clinic has doctors, nurses, counsellors and free medication and that she intended to go to the clinic’s psychiatrist and physician.

Very few of the study’s participants had a General Practitioner prior to prison. As a child, Miriam said that she relocated frequently with her family, who never worried about fostering a relationship with a doctor. Miriam, who was not incarcerated until her early 60s, was a heavy

smoker before this. She suffered from asthma and emphysema but said she generally relied on over-the-counter pharmacy medications to help alleviate symptoms. At the time of entering prison, Miriam was also diagnosed with cardiovascular disease and Type 2 diabetes, brought on by smoking and obesity. De Winter et al. (2012) highlight the fact that obesity and cardiovascular disease are major health problems associated with older people with cognitive disabilities, particularly women, generally related to poor diet and smoking. Miriam said that prior to prison, "I didn't really bother with any of that stuff [seeking medical help]. I didn't even know what diabetes was".

As one prison psychologist said:

> Often, it was a case of 'you don't know what you don't know' and so they [the women] didn't ask for help, and they didn't have anyone in their lives keeping an eye out for them. A lot of what they came to prison with could have either been prevented or treated.

According to the World Health Organisation (WHO) (2008) social exclusion is one of the most significant factors in generating and maintaining health inequalities. Of relevance to the women in this study is the phenomenon of "reverse causation" (van Bergen et al. 2019: 575) whereby compromised health and disability, such as cognitive disability and mental health disorders, produce and fortify social exclusion (also see Graham and Kelly 2004; Guthrie et al. 2013; Wilkinson 1999).

For the most part, the women did not address their health issues while in the community. In part, this stemmed from family disconnection from medical services. Some of the women hoped that conditions such as STIs would simply go away with no medical intervention. The women's narratives illustrated the connections between the determinants of health, discussed in Chapter 2, and their close relationship with social exclusion.

4.6 Domain 5: Agency on the outside

In his discussion of cognitive disability and agency, Jennings (2010: 178) provides an understanding of agency as "the capacity for independence and self-reliance; and the human need for an appropriate social and cultural environment that provides the individual with various types of resources - material, symbolic, spiritual - necessary to live a developmentally human life". Wolff (2010) maintains that for people with cognitive disabilities, individual agency is valuable, and yet they often have little scope to exercise agency in their lives. Many need to rely on others, over whom they have little or no control, to meet physical, psychological, or economic needs (Araten-Bergman et al. 2017). The following discussion highlights the

inability of the study's participants to initiate and maintain any form of agency, contributing to their overall state of powerlessness and marginalisation.

4.6.1 Agency and decision-making

Kohn et al. (2013) argue that people with cognitive disabilities are faced with significant challenges when it comes to decision-making. These challenges may be the result of the disability itself, which makes analytical and cognitive tasks more difficult, but also because of their social environment. For example, stereotypical attitudes towards those with cognitive disabilities potentially denies them any opportunity to develop and practice decision-making skills. Throughout the study's data collection, the notion of 'decision-making' was addressed by the women in negative terms. Among the mothers interviewed, several blamed themselves for poor decision-making that led to the involvement of CPS and the removal of their children. During the conversation with Rosie, she repeatedly said that she wanted to regain custody of her daughter but acknowledged that it would be difficult because "I made bad decisions [with drugs]. I can't blame anyone else". Theresa also referred to poor decision-making with respect to drugs. She has had 10 custodial episodes and commented that each time she is released she tries to stay away from drugs, but has had very limited success with this. She said, "This has to be my last stint in here [prison]. I'm getting too old for this". Similarly, Amelia, at age 50, said that even though she resolved to stop using substances every time she exited prison, she could not maintain abstinence. She said, "You know I used to have my own house before I came here. Drugs and drink happened. I lost my house and everything".

Wilson et al. (2017) argue that being socially included improves the ability to make decisions. However, there was very little evidence of the women's autonomous or 'safe' decision-making prior to incarceration. As Wikler (2010: 184) argues, "the standard reason for denying full freedom of decision-making to the cognitively disabled is the alleged danger to themselves and to others" and that "while it would be wrong to place restrictions on a normal person posing exactly the same threat to her own interests, restrictions on a cognitively disabled person would seem to be justified by her mental disability" (2010: 185).

Poor decision-making was not only due to cognitive disability. For most of the women, there were no positive role models at any stage in their lives to demonstrate a process of constructive decision-making, or to advise them as to how to resolve the consequences of a poor decision. A further related concern identified by Kohn et al. (2013: 1137) is the "potential for coercion or other inappropriate influence by a representative or supporter" through issue-framing or even a conversational style that may lead to a decision reflecting the desires of the 'supporter' rather

than those of the person, allowing "largely unaccountable third parties to improperly influence the decisions of persons with cognitive disabilities, thereby disempowering persons with disabilities and undermining their rights" (2013: 1157). This was evident among the women in the study, such as Belinda and Sally, who were persuaded by court-appointed legal representatives to enter a plea of guilty, which although shortening the process substantially, gave these women no opportunity to participate in decisions about their own court case.

From the women's narratives, it is apparent that decisions to change their circumstances mostly involved running away from abusive environments, but this usually ended in homelessness. As their stories illustrate, a common situation was one in which they were subjected to the actions of others, of being constantly on the receiving end of decisions involving what was done to them, rather than having capacity to decide 'what I will do for myself'.

4.6.2 Agency and goal setting

McConkey and Collins (2010) highlight the way in which social exclusion operates by denying or dismissing the ability of cognitively disabled people to set goals (also see Malik and Obhi 2019). As they point out, goal setting is a valuable tool for promoting social inclusion, especially for engaging with the process of managing challenging behaviours (also see Emerson et al. 2000). Additionally, Gardner and Carran (2005) argue that goal setting and decision-making for those with cognitive disability improves key areas such as having their rights respected. Asked if they had ever set goals prior to coming to prison, participant responses were typically vague and appeared to be something they were either unsure about or had not previously considered. Phrasing questions about goal setting in a specific context, such as learning to cook a particular dish, or applying for a job, elicited answers from some women, but not others, who just replied, "no". However, when asked about setting goals post-prison, most were forthcoming, with answers primarily focused on remaining substance free. Melanie said that she wanted to do a drug and alcohol course as well as a parenting course when she left prison. Rosie also said that she wanted to a parenting program when she was released. Alice's goal was to "help my mum in the school tuck-shop".

Several of the women cited literacy and numeracy as goals they wanted to achieve outside prison. Emotional regulation skills were also identified. Rachel's goal was to "not let people bug me. I'm not letting other people cause me to mess up". Susan's goals were to "get my anger under control, and don't use drugs". Improving physical health was mentioned by a few women. Susan said that when she was released, "I'm going to walk everywhere so I can get back into shape". The way in which goals were expressed by the women varied substantially, from those

such as Alice, whose goal of helping her mother in the school tuck-shop reflected more of a commitment to community, as opposed to goals stated by others that were centred more on an isolated event post-prison, such as Theresa's goal to go on a lawn-bowls trip with her partner.

Very few of the women were able to recognise and/or articulate notions of their own abilities. Noelene said that she was "good at art" and Alice said that she did "really good scrap-booking and card-making". No-one identified less perceptible abilities, for example, being able to listen to others or offer comfort. Self-esteem was generally low, with few participants able to express why they should value themselves. This was one area that, despite using an appreciative inquiry and strengths-based approach, the women did not, or could not, find a reason why others might appreciate them, much less why they should value themselves. Yet, as McConkey and Collins (2010) argue, the acquisition of skills whereby cognitively disabled people are able to recognise their value as a human being is at the very heart of social inclusion.

When asked about their dreams for the future and if they thought those dreams might be achieved through setting goals, most of the women were unable to associate dreams of what might be with goal setting. For most of them, dreams represented something unattainable, for example, having a house of their own or going somewhere nice for a holiday. Goals were more concrete, such as doing some sort of course. Questions on whether their dream could in fact be a goal were met with a negative response. An attempt to engage participants in a conversation around transforming a dream into a goal via planning was generally a 'step too far', and their narratives revealed an impression of being overpowered by the present such that future dreams seemed impossible.

4.6.3 Agency and life skills

Life skills, or adaptive skills, generally referred to as 'adaptive functioning', is premised on three key skill sets (Keller and Hayes 1997; Papazoglou et al. 2014; Salekin et al. 2010). First, *conceptual skills*, which include reading, numbers, money, time and communication skills, form the base for other skill sets. Second, *social skills*, which include personal interactions with others, understanding and following social rules and customs, obeying laws and being able to ascertain the motivations of others in order to avoid victimisation, are important, especially in the context of cognitive disability. Third, *practical life skills*, which include, for example, personal hygiene, contribute to health and wellbeing.

The absence of life skills was noticeable throughout conversations with the women and was something identified by all prison practitioners as contributing to both vulnerability and criminality. Compromised adaptive functioning was conspicuous across both social and

personal functions and could generally be linked to the circumstances that the women experienced prior to their incarceration. Very few of the women knew how to look after their money and there were many examples of losing money through coercion. For some, such as Alice, Georgina, Sally, Jennifer, Maddie and Caroline, the Public Trustee assumed responsibility for their finances prior to prison, which continued during their incarceration, providing them with a small weekly allowance to use for prison canteen purchases and phone calls. For others, like Belinda and Ruth, poorly developed life skills meant that despite court-mandated drug treatments for mental health disorders, they did not access recommended health services. Making and keeping appointments, interacting with medical practitioners and maintaining a steady commitment to any prescribed treatment did not happen, which prison psychologists said was an issue noted on their arrest records.

There were instances of women who were unable to pay bills or fines, because they either forgot to do so, did not have the money, or simply threw out the paperwork. As Hayes (2005: 98) points out, "poor adaptive behaviour relative to cognitive functioning may contribute to behaviour that results in the individual coming to the attention of police" and that "for most offenders, there are significant correlations between cognitive and adaptive abilities" (p. 102).

It was evident when speaking with the women that a lack of adaptive and life skills significantly impacted their ability to live and function safely in the community. For many of them, no-one had taught them the importance of developing certain skills and their narratives illustrated how an absence of essential skill sets contributed to unsafe relationships and practices.

4.7 Domain 6: Civic engagement on the outside

The notion of 'civic engagement' is important for two key reasons. First, little or no participation in social and cultural processes implies having a limited voice to influence the norms and attitudes that drive social exclusion in the first place. Second, participation is most often associated with relationships and networks that provide a sense of 'belonging'. In the absence of individual and economic resources, civic engagement such as community participation and caring for others within the community are particularly relevant to the study's participants. These associations have the potential to impart civic practices and values that may help the women manage the more unstable aspects of their lives, particularly trauma and homelessness, substance misuse and mental health, by providing new resources that open up new (positive) possibilities.

Domain 6 examines ‘community participation’ and ‘care of others’, with findings that reveal little engagement by the women in either. Authors such as Stock et al. (2011) acknowledge the many benefits of access to community settings and activities that are broadly accepted by mainstream society, such as social, recreational, vocational, educational and health needs, which are predominantly delivered in community settings. However, people with cognitive disabilities continue to face challenges with respect to accessing these resources, mostly because of ongoing stigmatisation and discrimination (Wiesel and Bigby 2014; Wikler 2010).

4.7.1 Civic engagement and community participation

Lack of community participation, a recognised element of social exclusion (Amado et al. 2013), was common to most of the women in the study. Renata, whose cognitive disability is due to an ABI in her early twenties, was the only participant who engaged in her community through regular participation in activities such as dancing and horse riding as a member of her local pony club. She was also a charity worker prior to her incarceration, responsible for organising fundraising and sponsorship for a number of different charities. None of the women had ever volunteered in community activities, for example, community clean-ups or tree planting.

For several women, substance abuse beginning in early childhood diminished their opportunities to positively engage in social or community activities. For others, parental, family, or peer modelling of community participation was absent. Some women were spasmodically involved in sporting activities. Noelene engaged in swimming at a local club for a few months before she was placed into foster care. She loved swimming and said she would like to be able to do it again when she leaves prison. Georgina played water polo at school, but like Noelene, had to give it up when she was in foster care. Bronwyn played basketball from the age of 12-15 but gave it up when other competitors teased her about her weight. Melanie played a variety of sports at school. She played touch football, soccer, basketball, cricket and softball, but said that once she began using substances, she no longer felt like playing.

Boardman (2011) also draws attention to the difficulties faced by people with mental illness in attempting any sort of civic participation, where stigma and discrimination remain as barriers (also see Smart and Smart 2006). What is regarded as ‘participation’ or ‘integration’ is often a case of physical integration but not social integration or inclusion (Amado et al. 2013; Thorn et al. 2009). Throughout this study, this situation was illuminated on many occasions, and it was the women themselves who came to believe this was normal, summarised by Rosie when she said, “it’s just how things are”.

4.7.2 Civic engagement and care of others

Aligned with community participation is the notion of care of others, and again, most of the women had not experienced this beyond the care of children at infrequent intervals. Notwithstanding this, despite living with a non-biological family involved in crime, Kelsey returned home when she was 16 following the death of her mother. Kelsey looked after her younger twin sisters because "there was no-one else". Her father was serving a long sentence for murder and Kelsey said, "I had to step up for the girls". Apart from Alice, no-one had ever volunteered for anything. Renata's job as a charity worker was a paid position and she did not work for any charities in a volunteer capacity. Alice did several months volunteer work for Meals on Wheels but gave it up because "they never even gave me any free food". Several of the women expressed a desire to do volunteer work post-prison, however, their criminal record would potentially prevent this.

Scholarship on volunteerism suggests it is a pro-social activity that mutually benefits both the volunteer and the community (Wilson and Musick, 1997; 1999). Importantly, volunteering discourages criminality and has a positive impact on self-esteem (Uggen and Janikula 1999). Similarly, Cobigo et al. (2012) argue that the experience of a valued social role, and being trusted to perform that role, is crucial to the social inclusion of people with cognitive disabilities. Scholars such as Hall (2010) and Simplican et al. (2015) maintain that for cognitively disabled people, social inclusion without a sense of 'belonging' via activities that seek to care for others in the community, or for the community itself, is to lose a vital component of social inclusion (also see Verdonschot et al. 2009).

This domain demonstrated the paucity of civic engagement for the women in this study. What also became evident in speaking with them was the fact that their lives could be substantially enhanced by this important area, inclusion in the community. The vagueness of the women's responses when talking about civic engagement highlighted their inability to conceptualise what this concept actually entailed, providing additional evidence of their exclusion from communities based predominantly on cognitive disability, mental illness and substance misuse.

4.8 Conclusion

This chapter explored a range of familial, social, structural and cultural factors underpinning the lives of the study's participants outside the prison setting. Domain 1 (informal networks on the outside) examined issues of family dysfunction, low socioeconomic status and disrupted communities as the foundation of social exclusion. Situations involving family violence, abuse,

homelessness and grief and loss, including familial suicide, contributed to the women's lack of social participation and integration.

Domain 2 (formal networks on the outside) revealed the way in which lack of inclusion in education and employment and overrepresentation in CPS and juvenile detention predisposed the women to later interactions with the CJS. For most, cognitive disability impacted their capacity to fully participate in their own legal proceedings. Domain 2 themes provided evidence of the way in which social exclusion, generated from lives characterised by poverty, dysfunction and violence, is reinforced by the structure and operation of institutions predominantly based on society's dominant norms and values that continue to position this group of women as 'outsiders'.

Domain 3 (trust and safety on the outside) highlighted the intersections with Domains 1 and 2. From the women's perceptions of trust and safety involving family and peers to trust/lack of trust in those operating as part of CPS and the CJS, the overall impression arising from the women's narratives was one in which experiences of trust and safety were generally viewed negatively. As with previous domains, cognitive disability was central, as the women's increased vulnerability left them exposed to abuses of trust.

Domain 4 (health and wellbeing on the outside) considered the women's health and its links to social exclusion. Substance abuse dominated the lives of many of the women in this study, emanating from familial and peer influence, but also as a response to experiences of trauma. Substance abuse was connected to compromised mental and physical health. Lack of access to medical services in the community meant that physical and mental health disorders mostly remained untreated.

Domain 5 (agency on the outside) was the domain in which the presence of a cognitive disability was especially influential, evidenced by poor decisions and those made as a result of coercion. Most of the women had little exposure to goal setting, and prison practitioners identified the women's overall lack of adaptive skills. As this domain highlighted, an absence of these skills undermines social inclusion.

Domain 6 (civic engagement on the outside), much like the domain of agency, was very limited. Lack of community involvement was due to factors such as the stereotyping of cognitive disability resulting in an absence of meaningful integration and participation. As this domain noted, civic engagement involves more than being physically included in an activity or environment – it includes the development and nurturing of relationships. For most of the women, there was an absence of these connections. Similarly, care of others was minimal.

The six domains discussed in this chapter offer something of a social exclusion roadmap, with clear signposts along the way that point to involvement in the CJS as a potential destination. Key themes of family, trauma, peers, CPS, the CJS, education and employment, addiction, mental and physical health, and (lack of) community participation are mutually reinforcing. In isolation, each theme, and the indicators within it, are recognised contributors to social exclusion. However, it is the interrelated nature of the domains, themes and indicators that generate and maintain the condition of social exclusion. Into this complex mix, cognitive disability is incorporated, adding layers of vulnerability that magnify the effects of social exclusion. As this chapter illustrates, susceptibility to coercion and an inability to rationalise the consequences of certain behaviours has implications not only for embedded social exclusion, but also for an interface with the CJS and trajectories into prison.

Chapter 5: Off to prison - you know the way…

5.1 Introduction

Moving from domains outside of prison, Chapter 5 examines domains of social exclusion *inside* prison. These findings will be used to address Research Question 2: How does social exclusion manifest in prison for women with cognitive disabilities? The chapter is framed by the domains of social exclusion identified in Chapter 3 and explores formal and informal networks, trust and safety, health and wellbeing, agency, and civic engagement *inside prison*. While several themes align with those discussed in Chapter 4, such as the role of family and peers, education and employment, and mental and physical health, a discrete perspective is presented in this chapter that reflects the very different environment in which these themes are being considered.

A central focus of this study is cognitive disability and its relationship to social exclusion. Social exclusion is generally viewed as something that only takes place in communities and societal institutions. A common perception is that once a person is incarcerated, they are considered to be socially excluded. As Braithwaite (1989: 179) maintains, "Prisons are warehouses for outcasts", while Smith and Stewart (1997: 106) contend that prison is the "the most extreme form of social exclusion, in that it removes people physically, mentally and emotionally from society, their community and family". Women and practitioner narratives presented in this chapter provide evidence of the way in which social exclusion continues to impact the women's lives inside prison, an environment that is exclusionary. Cognitive disability is central to their lack of inclusion in programs and prison work options and instrumental in further eroding trust and safety through vulnerability to physical, emotional and financial victimisation. As Chapter 2 identified, cognitive disability is also associated with challenging behaviours, which in the prison setting are addressed by the use of punitive measures such as solitary confinement.

5.2 Domain 7: Informal networks on the inside

Domain 7 brings to the fore the way in which the women in this study experience social exclusion inside the prison. The role of peers assumed a greater focus in an environment from which there was quite literally no escape. Bullying, intimidation, coercion and ridicule all featured prominently in the lives of many of the study's participants, sometimes resulting in their accommodation in protective or 'safe' units. Cognitive disability, which contributed to the women's vulnerability, was evidenced by their susceptibility to coercion, especially in matters of money and behaviours attracting prison sanctions. Relationships with family were, in many

instances, fractured by incarceration, particularly for women with children, who for the most part did not want their children to know that they were in prison.

5.2.1 Informal networks: Family

Foster (2012) highlights the repercussions for incarcerated mothers arising through lack of contact with their children. Toohey (2012) argues that children's visitation is fundamental, not only for the emotional wellbeing of incarcerated mothers, but also for children who are able to better understand their mother's absence (also see De Claire and Dixon 2017). However, at the time of interview, Melanie and Renata were the only mothers in the study who had visitation with their children. Melanie was able to see her children once a fortnight when their foster mother brought them to the prison for playgroup. However, Melanie said that when it was time to say goodbye, both she and her children became extremely upset. Renata gave birth two weeks after coming to prison. Renata's mother was the baby's primary carer, bringing her to visit Renata every day for two hours. Renata said, "it helps a bit, but I hate it when they walk out the door".

Some mothers said that they did not want their children to see them in prison and in fact had not told their children the truth about where they were, instructing carers to fabricate a story about their absence. Susan, whose children were in foster care, had not seen them for over three years. Susan said, "I used to ring them every Sunday but not since I've been here [prison]." She told their carers not to tell the children where she was. She felt it was better to say, "Mummy's gone on a holiday to sort herself out. They don't need to know". Belinda was incarcerated a long way from her community and her children's foster carers had not brought them to see her. Rosie was adamant that she did not want her seven-year-old daughter to see her in prison. Like Rosie, Mary said that she did not want her children or grandchildren to see her in prison.

The majority of women participants did not have any regular visitors, and some, such as Caroline, Maddie, Belinda, Jennifer and Molly, had never had a visitor or even a phone call during their incarceration, which in Caroline's case was over 12 months. Lack of formal identification was cited by prison psychologists as a reason why a number of the women did not receive visitors. Belinda, Sally, Maddie and Caroline's family members had no formal identification, although prison practitioners were unsure as to whether their families would have visited even if they did have the appropriate paperwork. Having to pass a criminal history check and negotiating the complex and often shifting prison rules and regulations were also noted by practitioners as impediments to visitation. TWCC's ALO pointed out the difficulties associated with trying to maintain connections between the women, particularly the Indigenous women,

and family members, particularly lack of access to transport and the substantial distances between remote communities and the prisons: “Visiting the prison is a problem for those living remotely. There is a bus service for prison visits but there is only one pick-up and drop-off point, so it’s really easy for people to miss out if they’re a few minutes late getting to the pick-up point” (ALO TWCC).

A practitioner from TWCC said that the Justice Groups, especially the one based in Townsville, occasionally visited the prison and were particularly helpful for Indigenous women. She stressed that connections with family and community were essential, and in her experience, were helpful in reducing reoffending. “Family links are crucial, and for the Indigenous prisoners the involvement of community Elders” (ALO TWCC).

Another issue with visitation pertained to the role of prison staff, especially custodial officers. Prison staff, who must facilitate visitation, often find it organisationally problematic, and so may be unaccommodating towards those who are visiting, making the exercise a negative experience. Practitioners in the participating prisons recognised that while visitation was generally a positive contribution to the women’s in-prison lives, they said that sometimes custodial officer attitudes towards visitors could be abrupt and unfriendly, which upset both the women and their visitors.

Phone-calls featured more prominently as a means of communication with family. Several participants cited the cost of phone-calls from prison as prohibitively expensive, stating that they could only call if family members put extra money into their prison accounts for them. Bronwyn, Rosie, Miriam and Rachel said that they depended on family to provide the funds for phone calls. However, Rosie said that she did not want her daughter to know about her incarceration and so she did not call her. She said, “I don’t want her picking up the phone and hearing a man’s voice on the other end”. (An officer needs to speak first to verify who is on the other end of the phone-call). Rosie’s grandmother put $5.00 into her phone account each week, which Rosie used to call her.

An absence of visitors and phone-calls is not unique to the study’s participants. It is a situation experienced by many incarcerated women (De Claire and Dixon 2017; Turanovic and Tasca 2017). However, cognitive disability was a factor that potentially impacted visitation because it contributed to coerced breaches of prison rules and regulations, resulting in confinement in maximum security and subsequent restrictions on visitation.

The narratives of the women and prison practitioners provide a synopsis of the women’s connections with family and children during their incarceration. It was apparent that family

visitation was problematic on several fronts, not the least of which were prison protocols that excluded family members unable to meet strict visitation requirements. Lack of formal identification was the main reason, along with an inability to pass criminal history checks. While prison practitioners said that visitation was potentially beneficial, they also noted that rules and regulations could not be compromised to facilitate visits by family who failed to meet the criteria.

5.2.2 Informal networks: Peers

The nature of the prison environment, in which the women live in close proximity to one another, increases opportunities for intimidation, both physical and psychological, in particular, the marginalisation of women who are regarded, as was the case for several study participants, as 'easy targets'. Bullying was identified by most of the women as an ongoing issue in their lives. A number of women said that they had spoken to custodial staff about being bullied but had not received any satisfactory resolution. Caroline felt that other prisoners targeted her. She tried to tell the custodial officers, but they did little to address the problem apart from speaking with the main instigator. Caroline said that nothing changed because of this. She was allocated a cell of her own to alleviate the number of bullying incidents. Sally also said that she had been bullied constantly in prison. This mostly took the form of name-calling - "people say nasty things to me". Sally worked in the prison as a cleaner for which she earned extra money. Unfortunately, other prisoners took financial advantage of her, forcing her to use her money to purchase things for them. During her first custodial episode, she was placed in the Safe Unit because of the vulnerability associated with the theft of her weekly 'buys'. The prison ALO said that immediately prior to the time of Sally's interview, the Public Trustee assumed responsibility for organising the money necessary for her purchases.

Bronwyn was very vulnerable and easily influenced. The prison psychologist commented that when she was in solitary confinement, Bronwyn banged the walls and constantly shouted, keeping other prisoners awake during the night. This prompted retaliation in the form of threats from the other women such as, "we're coming to get you and we're going to get your dad too". Other prisoners called her a "screw-lover" because several of the custodial officers played card games with her and Bronwyn also talked to them when she was feeling unhappy. Bronwyn was transferred to medium security on two occasions. However, this was problematic because there were many more people around her; greater levels of drama, conflict and confrontation; and more instances of bullying, all of which she found difficult to cope with. An inability to discern when she was being 'set up', and a ready acquiescence to breach rules to win favour with the other women, contributed to further instances of ridicule and to disciplinary outcomes:

> She [Bronwyn] gets egged on, she gets encouraged to do those things [lash out at officers], but she doesn't like that, she doesn't want to do those things, but she feels pressured to do things that she doesn't really want to (Psychologist 2 MHWP).

The psychologist said there were certain words and phrases that triggered Bronwyn's outbursts. Being called 'an idiot' or a 'retard' sparked a reaction that resulted in a return to maximum security.

Research by Leddy and O'Connell (2002) discovered, somewhat surprisingly, that despite a hypothesis positing that victims of bullying in women's prisons would generally be younger (i.e., under the age of 30), it was in fact older women entering prison who were most susceptible to victimisation, perhaps due in part to not having been 'socialised' into prison life. Miriam, who was not incarcerated until she was 63, spoke at length about being bullied in prison. As an older incarcerated woman (aged 68 at the time of interview), the younger prisoners "give me a hard time. They treat me like shit". Miriam was serving her sentence in protective custody due to the nature of her crimes (sexual abuse of her children). She shared a cell with another woman who constantly referred to Miriam's cognitive disability, calling her "hopeless", "useless" and "a retard". Miriam said, "on the outside I try and laugh, but I am crying on the inside".

Renata said that she has been bullied both physically and verbally since coming to prison and kept to herself to avoid further instances. "It's easier that way. There's always someone who doesn't like someone". Susan said that the worst thing about prison was "being picked on". She said, "another girl came in here and she got bashed. I'm just surprised I didn't get bashed". She went on to say, "I complained to the officers, but I got into more trouble [with the other women] for complaining to the officers". Susan was placed on a safety order in the Detention Unit. Practitioners identified that threats also revolved around causing the person to get into trouble so they would be moved to a different (generally more secure) unit. Emotional abuse was another factor, with other prisoners using personal information, such as 'your kids are in foster care and it's your fault' to evoke feelings of shame and guilt.

Overall, peer associations within the prison reflect those highlighted in Chapter 4. Susceptibility to coercion and to emotional abuse, which affected the women outside the prison, continue to impact them during incarceration, with the notable difference that the prison setting augments these tensions by a lack of discrete physical spaces. In considering 'peers' within the context of the prison, the women's narratives, as well as supporting evidence from practitioners, indicates that prison substantially contributes to the exclusion of cognitively disabled women. Behaviours resulting in a change to more secure accommodation, arising from coercion by other

women, added to exclusion by placing some of the women in restrictive accommodation, thereby preventing interactions with other women.

5.3 Domain 8: Formal structures and processes on the inside

Domain 8 considered the formal aspects of prison life and the way in which prison processes and protocols exclude women with cognitive disabilities, for example, through lack of program and work options and deficiencies in communication with agencies such as the CPS, responsible for the children of several of the study's participants. This domain explored key concerns such as court appearances via video link, remand in custody, prison reception and the women's lack of capacity to obtain either bail or parole - issues directly related to the presence of cognitive disability. This domain also investigated the mental and physical health of the women participants, both of which were impacted by incarceration. Self-harm was especially prevalent. Relationships with prison staff were also covered in this domain, with a focus on matters of trust and safety. These themes contribute to building a picture of exclusion that moves beyond the informality of peers and family to consider the function of the prison itself and the prison personnel who manage all aspects of the women's lives.

5.3.1 Formal processes inside prison

Part of being socially included is having access to justice. The United Nations Office on Drugs and Crime's *Handbook on Prisoners with Special Needs* (2009: 50) states that "special needs relating to their disability should be provided for during the *entire criminal justice process* [emphasis added] to ensure that they can participate in the procedure on the same basis as others." However, as McSherry et al. (2017) recognise, for many people with cognitive disabilities this is not always possible (also see Gray et al. 2009). Once incarcerated, initiating a legal course of action is challenging. For example, several of this study's participants were unable to navigate the call centre model of communication used by agencies such as Legal Aid. Following automated prompts often ended with them hanging up the phone or being cut off because they exceeded the time limit on phone calls allowed by the prison. If they managed to get through to a person on the other end of the phone, attempting to explain their situation when they were not exactly sure why they were in prison was also a significant barrier to progressing their case. The following examination of prison processes is informed by women and practitioner narratives that speak to the experience of video links for court appearances, prison reception and remand in custody.

5.3.1.1 Formal process: Court attendance via video link from prison

Overall, the findings of this study reflect those of Cockram (2000) in that a court date was something of a fluid concept. The challenge of going to court while incarcerated caused high levels of anxiety, especially for women who had to appear via video link. They were completely dependent on others to ensure (1) that the process was initiated and (2) once an appearance had been scheduled, nothing untoward at the prison (e.g., a lockdown) would prevent the proceedings from going ahead. Language was also an issue. Some of the legal representatives and magistrates used plain language, but in other cases the complexity of legal language was daunting and the women had little or no comprehension as to the reasons behind judicial decisions or the processes involved. For several of the study's Indigenous participants, English was not their first language and so they were dependent on the ALO to help them through the process.

The extent of Sally's confusion and anxiety about her impending court appearance via video link was apparent throughout her entire interview. There was a naivety to her narrative that was particularly compelling. She was certain in her belief that by reassuring the judge that "I'm going to be good now", would be sufficient to have her sentence overturned. She had no comprehension as to why she was in prison, wanting only to be allowed to return to her community. Despite constant assurances that the ALO would obtain the necessary information about dates and times and inform Sally as soon as possible, it made little difference to Sally's agitation. Molly was also highly confused about court proceedings. She was due to have a court hearing via video link the day after her interview, but said, "I won't know what's going on". Even with support, the court appearance was likely to present many challenges for Molly.

For each of her court appearances, Bronwyn was transported by the prison to the Magistrates' Court. The psychologist said that this was very stressful for Bronwyn due to the mandated strip searches prior to leaving the prison and then again after arriving back there from court. Bronwyn routinely refused to put her clothes on for court, staying in her cell in maximum security in her underwear. She often yelled and screamed, attempting to harm herself by banging her head on the cell floor and walls. Prison practitioners said that changes to court dates elevated Bronwyn's anxiety levels and contributed to her worsening depression.

Amelia was extremely upset and confused not only about being in prison, but her video link court appearance. Her interview's opening statement was, "I'm upset with the government". In relation to the charges of break and enter, for which she was incarcerated, she said, "I don't deserve to be in prison. I told the judge that I was invited into that house. They said I bashed

them, but they gave me the thing. How can I be arrested when they invited me in and gave that thing to me? I don't understand that". Amelia wanted to apply for home detention, but the prison counsellor indicated that the judge in Amelia's case was firm about her serving her sentence in prison.

5.3.1.2 Formal processes: Prison reception and women/staff interactions

Questions about the prison reception and induction processes drew mixed reactions ranging from "terrifying" to "awesome". Overall, most of the women were frightened during prison induction, particularly those who were entering prison for the first time. Alice described the induction procedure as "shitty, but sort of ok". The officers explained that most of the questions she was required to answer were to do with her mental health. Conversely, Rosie said that the induction process was, "really awesome. The officers were really kind and explained everything to me". When asked about prison reception, Susan said that "everything about it was scary". She felt that things were not explained to her and she was not seen by a psychologist. She was left alone in a cell for "a really long time" before anyone came to speak with her. Erica commented that when she came to prison, she was "terrified" and so she was placed immediately in the Safe Unit. She was particularly frightened of the other women. The induction process was done later when she had calmed down and had seen a psychologist.

The identification of cognitive disability was inconsistent across jurisdictions. In a few cases, such as Rachel, the presence of a cognitive disability was noted by the state disability service, so it was a matter of record, included in information passed on to the prison. The HASI was not routinely employed by participating prisons, mostly due to time constraints, and at the time this research was conducted, only Bronwyn and Kelsey had completed the test. IQ testing was also used infrequently and was not regarded as beneficial by prison psychologists. As the psychologist from TWCC commented when speaking about Jennifer:

> It is very difficult to test her cognitive ability using WASI [Wechsler Abbreviated Scale of Intelligence] as she is never in the right space to do it. She says it makes her "feel dumb". To be honest, the scores would add nothing of value to her life.

Responses to questions at the time of reception, such as 'Do you receive the DSP (Disability Support Pension)?', 'Do you think you're a slow learner?' and 'Did you ever attend a special school?', are used as guides for evaluating whether the person has a cognitive disability. If the person answers 'yes', they are flagged as having a disability. In Mary's case, for example, she answered 'yes' to the first two questions and so she was recorded as having a cognitive disability. As the BWCC psychologist remarked, "it's not a particularly robust guide as to

whether someone has a disability, but it's what we tend to go on". These questions form part of a generalised risk/needs assessment administered to every woman who enters prison, administered by prison staff and not necessarily by psychologists.

When speaking about prison reception processes, the women were not asked about strip-searches, although several, such as Kelsey, Renata and Mary, spoke about their traumatising effect. Kelsey said, "I was suicidal, but I was left naked in a room with full-grown men. They know I've been interfered with, but they didn't care". Renata was traumatised by strip-searches conducted within hours of giving birth to her child in hospital. Renata's baby was removed from her almost immediately, with Renata transported back to prison and strip searched upon her return from the hospital. Renata broke down and cried as she described the humiliation of this search. She said that she thought about it continually and that "my brain can't escape, especially at night-time. That's the worst. The picture just pops in there, even though I don't want it to". Mary was deeply affected by strip-searches conducted many years ago when she was first sent to prison at the age of 22. Despite the historical nature of this event, she could still remember the name of the officer who conducted the search and said that their face was "burned on my brain".

Overall, practitioners believed these searches were harmful to mental health and were dangerous for women who had suffered sexual abuse. "It's upsetting that we can't do it on a case-by-case sort of basis. Ok, she's been strip-searched twice already today, and you haven't found anything. Any chance of leaving her alone?" (Psychologist 1 MHWP). However, some staff were resigned to this practice, stating that the searches formed a necessary part of prison safety protocols. "From an ethical and therapeutic standpoint, if I could say no strip searches, I'd say it 10 times a day, but it's beyond us, it's part of the system and the way it works" (ODM AWP). These findings were somewhat surprising, given the level of care and concern expressed by prison practitioners for the women participants. Acknowledgement of harms caused was not accompanied by a universal condemnation of strip searches, with most staff viewing them as a 'necessary evil' and an important aspect of prison security.

5.3.1.3 Formal processes: Bail, remand in custody, the women and prison practitioners' perspectives

In most Australian jurisdictions, legislation supporting more punitive approaches to punishment now enables a greater use of remand, which disproportionately affects people with cognitive disabilities and mental health disorders (Human Rights Watch 2018; QAI 2016). Significantly, cognitive disability is a crucial factor. Practitioners highlighted that most of the women

remanded in custody were there because the courts were not persuaded that they would be able to adhere to bail conditions.

Figure 5 illustrates the fact that almost 50% of the study's participants were remanded in custody at the time of interview. At this time, Caroline had been remanded in custody for 13 months. In several cases, the view of prison practitioners was that had the women been to court much earlier in the process, their actual sentence would have been less than time served on remand (see Brown and Kelly 2012; QAI 2016; ADCQ 2019).

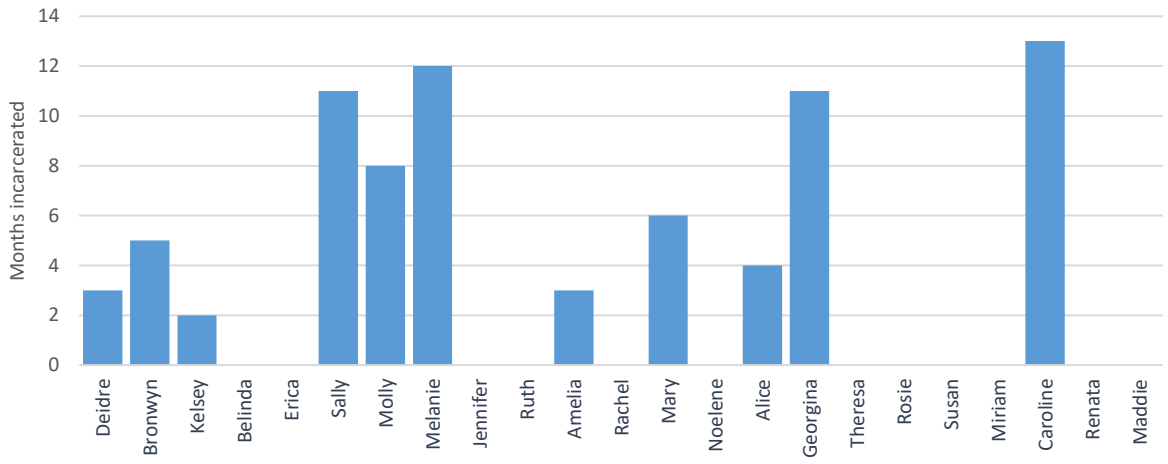


Figure 5: Months remanded in custody

At the time of interview, some of the women remanded in custody experienced several court adjournments, which added to the time spent incarcerated:

> At the moment it's all about the courts and the slowness of the system. Several of the women have served more than enough time [on remand], but because of lengthy delays in court proceedings, their cases are unlikely to be reviewed in the foreseeable future (Psychologist TWCC).

Prison practitioners in each prison noted that women remanded in maximum security, particularly those impacted by delays in having their matter heard, suffered from high levels of anxiety and depression, with an increased risk of self-harming behaviours. For women with cognitive disabilities, this was something noted by practitioners as one of the most difficult situations to manage inside the prison: "Being on remand for her [Bronwyn] is really stressful. She doesn't really understand the court processes very well, so is very confused each time she comes back and isn't sentenced or doesn't get out" (Psychologist 1 MHWP).

Remandees are usually classified as maximum-security prisoners. Most have no access to therapeutics or programs, and if they do, it is generally limited to minimal time spent doing

literacy and numeracy. While literacy is potentially useful, it is far removed from interventions aimed at dealing with trauma, addressing mental health and substance misuse, and assisting with adaptive skills. If women are remanded for 12 months or more, the shortcomings of these policies are evident.

5.3.1.4 Formal processes: Bail: "Straight back to nothing"

The granting of bail as the result of a judicial decision at the end of a court appearance means that the person is not remanded into custody, but for the women in this study, the reality was that without effective supports in place, breach of bail was a regular occurrence: "They come in, we're identifying the needs, and then they're bailed, and they disappear. They come back, start the ball rolling again, they're gone, they come back, and the revolving door is really difficult" (Psychologist 1 MHWP). The words "straight back to nothing" summarised the perceptions of several other participants. "One of the difficulties is, often Bronwyn is released to bail, and so she's just released straight back to nothing, you know?" (Psychologist 2 MHWP).

The narratives of the women and those of practitioners demonstrate that in the domain of formal networks and processes, cognitive disability is significant in shaping outcomes determined by a system that is unsympathetic to those unable to comprehend its workings. Few concessions are made on the grounds of cognitive disability, and as practitioner input on the matter of bail highlighted, bail itself is problematic in generating cycles of incarceration that intensify exclusion because of the inability of prisons to provide any sustainable support, either inside or outside prison.

5.3.1.5 Formal processes: Programs and employment

As many researchers identify, prison programs for women have traditionally been modelled on programs operating in male prisons with only minor modifications enacted to make them more 'gender sensitive' (e.g., Baldry 2010; Byrne and Howells 2002; Carlen and Worrall 2004; Carlton and Baldry 2013; Corston 2007; Covington 2004; Hannah-Moffat 1995, 2006; Young and Mattuci 2006). Vocational training programs often focus on preparing women for gender-stereotyped roles (Cameron 2001). As Chapter 4 demonstrated, the majority of the women in this study entered prison with significant deficits in education and employment skills, and as Domain 8's examination of formal prison processes demonstrates, for women with cognitive disabilities, in-prison opportunities for criminogenic program participation or employment were limited.

5.3.1.6 In-prison employment

Figure 6 illustrates the women's employment inside prison. Prison jobs generally consisted of gardening duties, laundry work, kitchen duties, rubbish bin duties, cleaning, rag cutting and sewing in the prison workshops. Of the study's 23 participants, only nine had a prison job. Apart from Renata's job in the prison kitchen, which amounted to 25 hours per week, the other positions were part-time, approximately 10 hours each week.

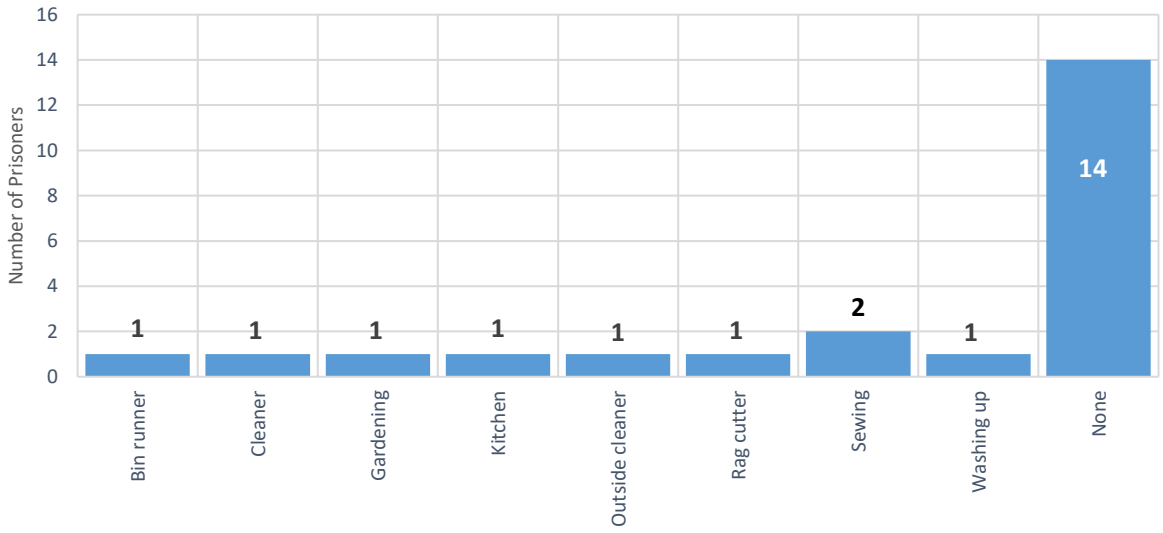


Figure 6: Employment inside prison

All prisons in the study offered generic jobs such as gardening, cleaning, kitchen duties and sewing. However, as Figure 6 demonstrates, less than half the participants had a job. There were several reasons for this lack of participation. First, security ratings determined whether the women had permission to work. Women in secure units were not permitted to work. This related not only to their accommodation, but also to the fact that several of them were medicated, including sedatives to keep them settled. Second, several of the women were deemed incapable of working, with practitioners citing cognitive disability and mental health as the two main factors contributing to this. Third, while sentenced prisoners were required to work (provided they were not accommodated in a safe or detention unit), those on remand were not generally given a job unless they requested it, and only then if there was one available. As Figure 5 illustrated, half the study participants were remandees, some of whom were accommodated in safe and detention units.

Women who were more high functioning were given prisons jobs. Melanie worked in the prison gardens, which she felt would help her obtain a job post-prison. Renata's job in the prison

kitchen involved more hours than any other participant. She worked six days a week, from 7.30 am to 11.30 am and from 1.15 pm to 3.30 pm. Renata said the kitchen uniform, consisting of black-and-white checked chef's pants and a black polo shirt with 'Kitchen Staff' embroidered on the back, made her feel "more normal". This was a substantial departure from the standard prison clothes of grey tracksuit pants and tops. Mary worked half-day shifts in the prison sewing workshop, mostly making the 'suicide gowns' worn by the women in the safety units. She liked the work and seemed not to be bothered by the nature of the garments she sewed. Amelia, Alice and Theresa said that they would like to have a prison job; however, practitioners said that they would not be given employment because of their low cognitive function and their inability to be able to interact with the other women.

5.3.1.7 Prison programs

Heseltine et al. (2011) draw attention to the lack of programs specifically designed for women, Indigenous women and cognitively disabled offenders. For women with cognitive disabilities, participating in mainstream programs is challenging. Rowe et al. (2020: 48) also highlight this point:

> Program participation that is person-centred, that places value in someone's innate strengths, has an important therapeutic and humanising effect that reduces the disproportionately harsh punishment that imprisonment represents for people with cognitive disability while also countering the personal and systemic disadvantages and trauma experienced by this group.

Criminogenic rehabilitation programs require participants to be 'responsive', which is problematic for cognitively disabled women who may be unable to respond appropriately to questions and tasks because of uncertainties in understanding the program content. Additionally, the women's accommodation, frequently in segregation or protection, also means restricted access to programs.

None of the participating prisons had any specialist programs for cognitively disabled women. The programs on offer were not generally pitched in a way that resonated with the women, even if they did manage to participate. In terms of programs for addressing criminogenic needs, several practitioners identified the continual cycling in and out of prison as the biggest challenge to effective intervention and support in this area, for example:

> With a lot of the intellectually impaired people that are in prison, when you mix in all the other needs, like antisocial peers, and the drugs and the alcohol, it's really complicated. I think it's the lack of stability and time and consistency, because they're in and out so much. That's the biggest challenge (Psychologist 2 MHWP).

Another concern expressed by practitioners was the fact that to obtain parole, prisoners need to have demonstrated an effort to change, mostly through program participation. The presence of cognitive disability was especially noticeable in discussions with practitioners regarding this issue. Not only did the lack of program participation impact opportunities for parole, the application itself was problematic for women who were mostly illiterate. The guidelines that advise how best to fill out the form require above-average literacy skills. Prisoners may or may not receive assistance depending on the availability of prison staff or prisoner advocates. Should this be successful, preparation for 'the interview' in front of the parole board is another significant hurdle to be negotiated. Most of the women in this study were not highly articulate and having to respond to questions about their 'remorse' and producing appropriate answers to questions about how they planned to 'improve' themselves were particularly confronting. As one practitioner commented, prisons need to provide a program just for learning how to navigate the parole application process.

With a long history of incarceration, Mary was one of the few participants who had developed a range of skills through program participation, for example, forklift driving and leatherwork. She had also completed the high-intensity substance abuse program several times, but despite this, Mary found it too difficult to remain substance free outside prison. Belinda had also completed the substance abuse course a number of times, but did not relate its contents to life outside of the prison. The prison psychologist said that these programs were, in Belinda's mind, "just for prison" and not for outside. As one practitioner commented, "addressing substance abuse is a big issue, but it is difficult because most of the women are returning to environments where it is part of the fabric and they find it too hard to stay off it" (ODM TWCC). None of the women involved in this study had participated in a domestic violence program despite high rates of victimisation.

When reflecting on the women's and practitioners' input into programs and employment as part of the prisons' formal processes, what is evident is the women's lack of inclusion in either. Employment and program participation offer two areas for inclusion in the prison setting by (1) providing occasion for positive peer associations, especially in programs that invite personal reflections and enhance listening skills, and (2) through interactions with program facilitators, who in many cases come from outside the prison and are frequently a source of personal affirmation for the women, helping to build self-esteem and a sense of self-worth. Most of the women in this study were not provided with participatory opportunities.

5.3.1.8 Formal structures inside prison: CPS

Chapter 4 drew attention to the role of CPS in the lives of the women in this study. This situation is mirrored by CPS involvement in the lives of their children. A problem cited by several women was the lack of communication between CPS and the prison, so that they did not know what was happening with their children and were not kept up to date about the children's education, state of health, and overall wellbeing and happiness. The women in this study whose children had been taken by CPS generally lost custody of them because of substance misuse and/or homelessness. Another matter of concern identified by several women, as well as prison practitioners, related to 'parenting assessments' conducted while the women were still incarcerated. Rosie said:

> The prison's said that I have to do all of these things, that I need to do this, that, and the next thing before they'll [CPS] even think about giving her [Rosie's daughter] back. They already said that because I was on ice, even if I do all the drug tests and whatever, it probably won't happen.

As Figure 7 illustrates, there was a high rate of foster care among the children of the mothers in this study. At the time of interview, 15 of the 23 women in this study had children, and nine of the women had two or more children. Of the 15 mothers, there were only five whose children were *not* in the state care system.

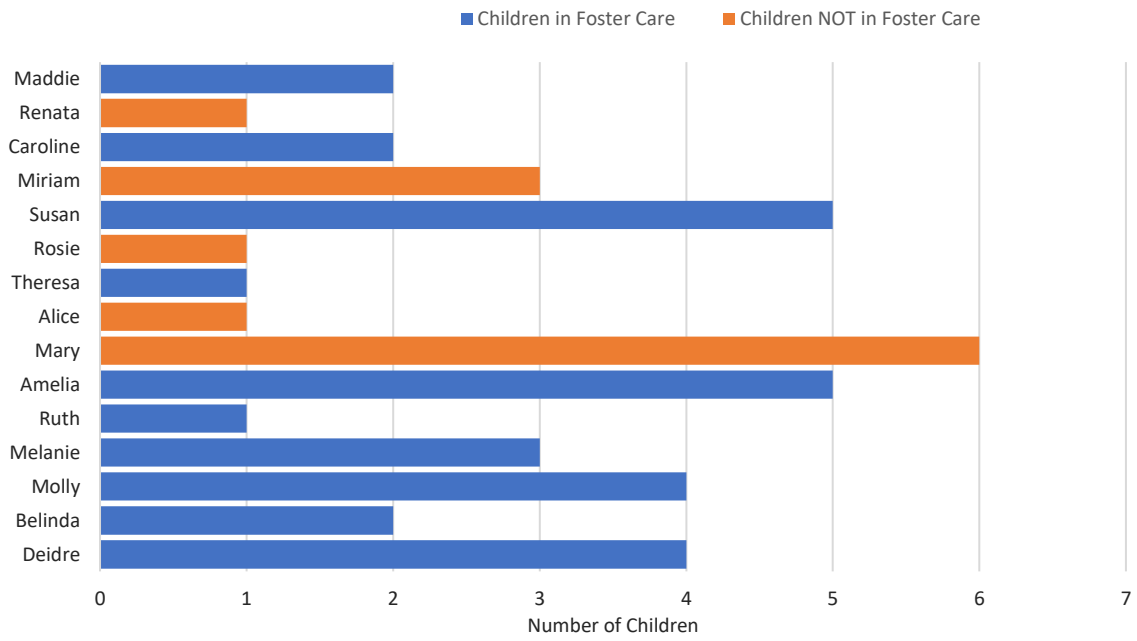


Figure 7: Participants with children in foster care

Melanie was very emotional during her interview when she said that CPS continually told her that her children were "settled and happy with the foster carer". She said she felt that they told

her this because “they just don’t want me to have the children back again. I just want to bawl my eyes out”. Belinda’s two children were both in foster care. Like Belinda, the children’s father had substance abuse problems and it was unlikely that either would regain custody of their children. Belinda had several visits with them when she was out of prison, but they were not brought to see her during any of her custodial episodes. Molly also had three children who were in the foster care system. The home they were living in was very crowded with 11 children placed there. At the time of interview Molly was pregnant with her fourth child. She said, “my other kids got taken. I’m going to let them take this one too”. Like Molly, Ruth was also due to give birth not long after her interview. The baby had already been identified by CPS for placement into care.

Amelia had three children, with the younger two in state care. She was unable to say where they were living or with whom and had not had contact with them for several years. Similarly, Theresa had a teenage daughter who was in foster care. She had not seen her for over four years. Her daughter was angry with Theresa, blaming her for using drugs and committing the crimes that led to incarceration, but Theresa said she felt that eventually her daughter would “come around, and we might be friends”. Susan had not seen her children (aged 11, six, four and three at the time of interview) for three years. CPS took each child away soon after their birth. Susan was deeply distressed and emotional during the interview when talking about this, mainly because she felt that her drug-taking and poor decision-making were the major factors contributing to the removal of her children. Her sons were in one foster home and her daughters in another. Susan used to call the children every week but stopped doing this when she came to prison.

The women’s narratives demonstrate the damage caused to parent–child bonds by the merger of incarceration and the CPS. The ramifications for the women were significant. Most of the study’s participants struggled to develop a positive identity, and for women like Rosie, Susan and Melanie, their role as a mother was important in fostering perceptions of themselves as ‘good people’. They felt they were better mothers to their children than their own mothers had been to them. However, each of the women whose children were in CPS care acknowledged that addiction was the main cause of this loss. Prison practitioners identified that cognitive disability was also factored into assessments of their parenting ability. For example, in Mary’s case, given that she had a supportive partner who was the primary carer for their children, cognitive disability was less of an issue because Mary was not tasked with being the sole decision-maker with respect to the children’s welfare. Conversely, for Susan and Melanie, who had no support systems at all, cognitive disability was raised as a concern by CPS. Unlike

addiction that had the potential to be overcome, cognitive disability was an irreversible factor, and this, along with the impact of incarceration, contributed to excluding these women from a parenting role.

5.4 Domain 9: Trust and safety on the inside

Trust and safety were not elements that all the women in this study believed could happen in the prison environment. Hibbitt et al. (2001: 154) maintain that, "One of the key elements identified in the literature on social exclusion and the value of social capital, is the importance of trust". People who have been chronically socially excluded often read hostility into the ambiguous actions of others, even if such actions are not intended as such (Eisenberger and Lieberman 2004; Kawamoto et al. 2015; Twenge et al. 2007). In the prison environment, this has repercussions for the reciprocity of trust and overall feelings of safety. When cognitive disability is also a factor, particularly when it impacts the capacity of the person to 'filter' information and keep emotions in check, then the issue of trust and safety is amplified by a setting that offers little in the way of spaces in which to retreat.

Links with Domain 7 (informal networks *inside* prison) were evident in terms of the women's interactions with other prisoners. Those who were bullied, for example Susan and Miriam, were less trusting than women such as Mary, who had a long carceral history and was more familiar with the 'way things work' in the prison setting. All participants trusted the professional staff, but trust in custodial officers was less widespread. Women housed in secure and detention units felt less safe than those accommodated in mainstream areas. Being under 24/7surveillance was stressful for those in solitary confinement.

5.4.1 Trust and peers

The 'prisoner code' was alluded to by two of the older women who lamented the 'solidarity of the sisterhood' as a thing of the past. Theresa said that while she felt safe in prison and had a good relationship with the officers, she was often bullied by the other women. She spoke about the changes to the prison 'code' that have evolved over two decades, saying:

> Nowadays there is no loyalty in the sisterhood. In the old days, if you dobbed on someone, they [prison staff] kept a note of stuff. These days, if you dob, everyone knows, so you get people saying, 'She's a dog' and then there's a fight. Once-upon-a-time the sisterhood meant that we all stuck together.

Mary also had a long history of incarceration. She said that she was happy to talk to all the other women as well as the staff and felt safe in all areas of the prison. She spoke about the women

she got to know over 20 years ago in prison who were still incarcerated with Mary. She regarded these associations as genuine friendships. Melanie also expressed feelings of trust when talking about the other in her unit. She said, “usually I don’t talk to anyone on the outside, but in here I talk to everyone. We’re all in one big boat”.

A challenge identified by prison practitioners related to the way in which cognitive disability impacted the women in this study. In the prison setting, where information can be used as ‘currency’, an inability to discern what information to share and what to keep private was problematic. For example, Bronwyn constantly spoke about her siblings’ drug use, which was then used against her in the form of threats, such as “give me money or I’ll tell the cops about them”. Bronwyn did not understand that the capacity of other prisoners to ‘tell the cops’ anything was extremely limited and so she generally did as she was told. However, most of the women did not maintain peer associations in prison. According to several prison practitioners, cognitive disability contributed to this situation, in that other prisoners generally found the women difficult to converse with. Relationships were often coercive, especially in terms of the women handing over their money, and (with only a few exceptions) there was little evidence of any genuine attachment. An additional component of prison relationships was the high ‘turnover’ of women entering and exiting prison, affording limited time in which to establish meaningful and trusting connections.

5.4.2 Trust and prison staff

Women who were ‘known’ to custodial officers as prone to violent outbursts ended up spending a great deal of time in maximum security. Some officers were understanding of the frustration driving these outbursts, others were not. Practitioners said that certain officers were disliked by certain women, inevitably leading to verbal and physical conflict. Prison practitioners also spoke about the fact that not all custodial officers were aware of the women with cognitive disability and how that affected their behaviour. Psychologist 2 from MHWP, when speaking about Bronwyn said, “it worries me that she gets punished for behaviour which is largely because of her disability. We’ve seen it over and over, and you think, ‘please, just don’t do this to yourself’”.

Others knew about the disability but were not prepared to overlook behaviours that did not align with prison rules and regulations. The psychologist from TWCC said there were a number of officers who did not understand the way in which cognitive disability affected the women’s functioning, especially aspects such as poor impulse control and susceptibility to coercion by other prisoners.

Notions of 'fairness' relating to matters of consistency, whereby "the application of prison rules and procedures in a flexible, accountable and unbiased manner" (Liebling et al. 2012: 369), were not always apparent to the study's participants (also see Butler 2019; Liebling 2011; Liebling 2009). Miriam spoke about the inconsistencies between custodial officers and dual standards that saw some prisoners favoured over others. She said, "the rules change depending on which officers are here. If you're young and pretty like (name) you get away with stuff. If you're old and fat like me, then you don't".

Molly was convinced that, "the staff inject me. They keep files on me. They talk about me all the time". In the secure units, conversations between psychologists and the women were not private and were audible to other women and to the officers on duty. This often shut down conversations, although in the case of several study participants, the opposite occurred, so that everyone in the unit overheard the personal information imparted to psychologists.

Practitioners also spoke of some positive outcomes for the study's women. These mostly pertained to developing strategies for recognising safe/unsafe situations and people and negotiating a path towards developing trust in others:

> We slowly but surely worked on all that trauma, to get her to trust us—first, the female staff, and making sure she felt safe to speak to new people, but only on Friday, she said to me, "Oh, you know Mark, he's my favourite supervisor." She said, "Do you think I would have said that three years ago?" (Psychologist 1 MHWP).

The psychologists at BWCC each had a 'POC' (Person of Concern). Four of the study's participants were part of this protocol. This meant that wherever possible, therapeutic interventions and one-to-one interactions would be managed by the same person to create a situation of trust. Dougherty (1998) echoes the sentiments of practitioners when she identifies the fact that before any meaningful rehabilitation or therapeutics can occur, practitioners have to dismantle the emotional walls that the women have built, establishing trust with a group of women who are predisposed not to trust authority figures who extend support (also see Swift 1998).

While there were mixed reactions from the women about custodial officers, all participants trusted the prison practitioners involved in this study. This was particularly evident with respect to the psychologists, who spent the greatest amount of time with the women:

> I've probably had more contact with her over the past few years than anybody, but I've probably had more contact with her in her life than most people, and on a very intimate level, because she's been talking about all these traumatic experiences that no-one else has really covered off before (Psychologist 1 MHWP).

The study's Indigenous participants relied heavily on the prison ALOs to support them in most aspects of being in prison, such as negotiating court appearances via video link, during the times when they were being held in secure or detention units, and organising Elder visits. Elders received complete endorsement from the study's Indigenous participants. Melanie said, "They keep me sane. They teach me. They make me feel like I mean something".

Counsellors were also viewed by the women as trustworthy and respectful. There was a clear delineation in attitudes about prison professional staff, such as psychologists and counsellors, and some of the custodial officers with whom the women did not feel safe. Women like Noelene, Susan and Amelia, who were accommodated in secure units, did not feel safe in prison because of 24/7 monitoring. Not knowing who was observing them via CCTV cameras was a cause of continual anxiety.

The investigation of Domain 9 produced mixed results in that some of the study's participants predominantly felt unsafe in the prison environment and felt that there were very few people they could trust, while others believed they were safe in prison with high levels of trust in prison staff.

5.4.3 Trust and safety: Prison as a 'refuge'

Segrave and Carlton (2010) observe that for many women, prison is the only place where they have ever felt a sense of 'community' and 'belonging.' Shared experiences and the notion of 'having friends' become a reality. From an existence marked by social exclusion, they transition to a setting where they feel included. The notion of 'community' was evident in Rosie's narrative. She said that when she was accommodated in 'Residential' (minimum security) she liked being there. She had friends. "The girls are lovely. They make me laugh". Rosie was an ice user but stopped because of incarceration. She said that being away from friends and family who were drug users was a turning point for her and that when she gets released, she wanted to stay away from everyone who had been a bad influence on her. Rosie said, "it [ice] took everything [from me]. Being here has made me see things differently. Because of prison I'm off the ice. It was a wake-up call".

Erica was only 17 years of age at the time of interview, but her cognitive age was assessed as being that of an eight-year-old child. She was accommodated in the mainstream prison population which created something of a 'family' for her. Because she was very childlike, the other women were supportive of her and protected her. Erica said that she enjoyed being in prison because "it's a bit like juvie [juvenile detention]. I get to go to school. I like school". For Erica, the prison structure and routine were comforting. She liked the attention she received

from the other women along with stable 'accommodation' and regular meals. She said, "I'm happy to stay here. I don't really know where to go if I don't live here".

For women with cognitive disabilities, compromised adaptive skills amplifies their vulnerability outside of the structured environment of the prison:

> I think some people definitely come back to prison for the sake of coming back to prison, because they feel safe and comfortable here. You say to them, "Oh, what are you doing back, what's gone wrong?" They feel supported by that, and all these familiar faces who care about them (Psychologist 2 MHWP).

Prison practitioners in all prisons noted that women sometimes breached bail conditions or committed crimes in order to be returned to prison. There were three main reasons for this: the women had nowhere to live, they were fearful of abusive relationships and they were frightened that they would return to substance use when they exited prison. As one psychologist remarked, "she's come a long way, but in a very controlled environment, and once you take away those safety nets…it's going to be more challenging for her". (Psychologist 2 MHWP).

As identified by Segrave and Carlton (2010), there are times when prison is a place of safety for women who have endured trauma, particularly violent and abusive relationships. This is not an endorsement for prison as a place of sanctuary; rather, it casts the prison as a setting that provides physical separation from a traumatic environment. In reference to Deidre, Psychologist 1 from MHWP said, "It [prison] was a safe place, away from drugs, with very few negative influences, and for the first time in her life, a lot of people who cared what was happening to her".

While prison may not be considered a 'therapeutic space', for some women it represented a setting in which structure and routine provided order to lives defined by chaos. Practitioners said that, in general, women with cognitive disabilities gained a sense of security from the expectations of prison, with regulations and routines that had to be adhered to. However, they were concerned that the women had to come to prison to find the type of support unavailable to them in the community. Several drew attention to cognitive disability as a barrier to accessing assistance, because the women either had no knowledge of available supports, or factors such as location (e.g., outside of towns/cities) or homelessness prevented access to agencies.

Drawn together, the women's narratives and those of prison practitioners reveal inconsistencies in notions of trust and safety inside the prison. Trust in peers varied, but this depended not just on the women's accommodation (i.e., minimum security or secure units) but also on the characteristics of the women themselves, with some, like Renata and Susan, fearful of other

prisoners, and others, such as Mary and Rosie, confident in the company of others. Trust in professional staff and prison Elders was unanimous, but trust in custodial officers was less so, with several women citing officer inconsistencies as a reason for their lack of trust.

Having trusting relationships and feeling safe in one's environment are, as Hibbitt et al. (2001) point out, mainstays of social inclusion. For the women in this study, especially those who entered prison having had feelings of trust and safety eroded over the course of their lives, developing trusting relationships was difficult. Paradoxically, other women felt a sense of 'community' and in prison practitioners discovered a relationship in which trust was a principal driver. In this domain, it was not possible to conclude that the prison fostered wholesale exclusion as there were several participants for whom the prison enabled positive peer and staff relationships and provided greater safety than they had known outside of prison.

5.5 Domain 10: Health and wellbeing on the inside

The findings of the AIHW's (2018) report, *The Health of Australia's Prisoners*, reveal a negative picture of the health of women prisoners in Australia. They draw attention to the high incidence of mental health disorders, histories of self-harm and the fact that women prisoners are more than twice as likely as male prisoners to be dispensed medication for mental health disorders. With respect to physical health, many women enter prison STIs, for which most have not been treated. There are also higher rates for women prisoners than men of asthma, arthritis, diabetes and cardiovascular disease. They are also more likely than women in the general community to smoke and to have used drugs and alcohol during pregnancy (Mukherjee et al. 2014).

The social exclusion of women with cognitive disabilities is highlighted by their vulnerability to disabling experiences within models of health treatment and management that disregard their input into decisions pertaining to health matters. In the prison setting, the issue of informed consent with respect to drug administration is sometimes questionable (see Hall and Lucke 2010; Mitchell et al. 2007). During this research, several of the participants were on mandated drug regimes, either through the courts or the Mental Health Tribunal, about which they had little knowledge. Tracy and McDonald (2014) point out that health and wellbeing underpin social inclusion, which is problematic in the community where cognitively disabled people continue to encounter barriers in accessing appropriate healthcare. In the prison environment, the barriers are different but nonetheless challenging for cognitively disabled women. For example, physical and/or dental issues required the person to fill out paperwork to be placed on

a list to be seen. For women who are illiterate or have low levels of literacy, this is difficult, and unless there is someone to help them their problem will potentially go untreated.

Mental health disorders were ‘managed’ rather than ‘treated’. Prison protocols of security and containment were at odds with a therapeutic setting. Women with severe mental health problems were routinely accommodated in heavily monitored ‘safe’ units. Pharmacological interventions were not uncommon. What became evident during the research process was the unsuitability of prison as a place to address comorbid mental health disorders and cognitive disability, with high levels of confusion and disorientation evident for several of the women. Withdrawal from substances was challenging, but addiction programs had limited success in producing sustainable behaviour changes. Apart from a minority of study participants who viewed incarceration as an opportunity to withdraw from substances, the prison itself contributed to a deterioration in health, particularly mental health.

5.5.1 Health and substance misuse

As Chapter 4 identified, early exposure to drugs and alcohol, being detained in a juvenile facility, mental health disorders, and histories marked by trauma are the most significant risk factors for substance misuse. Numerous researchers have identified connections between substance misuse and social exclusion (e.g., Brandova and Kajanova 2015; O’Gorman 2000; Rankin and Regan 2004; Spooner and Hetherington 2004; Todd et al. 2004), but as Chapter 2 highlighted, Buchanan (2004) argues that the two phenomena are mutually reinforcing. Several of the women recognised the role that drugs and/or alcohol played in the commission of their offending. For some, the withdrawal from drugs and alcohol was a slow and painful process taking many months—in Deidre’s case, close to two years. Overall, the women wanted to remain substance free when released from prison. They acknowledged that this would be dependent on peer and family associations. The motivation to remain substance free was particularly strong among women who were mothers. The women with very young children constantly referred to “when I get my kids back” as their reason for wanting to be substance free.

Women such as Mary and Theresa stated that they intended to remain substance free when they were released from prison. However, this had not transpired for either of them and they continued in a cycle of substance use, offending, arrest, conviction and incarceration. Mary participated in a high-intensity substance abuse program while in prison, but it had not had the desired effect. Mary’s partner was not a drug user, and he and her oldest daughter tried to support and encourage Mary’s desistance when she was not in prison. At the time of interview,

Bronwyn was receiving one-to-one alcohol counselling from a prison counsellor. However, like Mary, she found it challenging 'outside' to adhere to the messages imparted during these interventions, saying that "it's who I hang around with" that influenced her decision to drink again.

Some participants felt that prison helped them address their drug/alcohol addiction. Susan was in prison for crimes relating to drug possession and was previously a chronic drug user. She said that drugs were responsible for her incarceration and that coming to prison was an opportunity to get off them. Susan made an insightful observation with respect to her addiction: "When I was on the outside, no-one wanted to help me. Now they do. What the fuck? I need to come to gaol for you to help me?" Melanie was proud of the fact that she had been off marijuana for three years. However, she commented that the first thing she would do when released would be to "have a drink". She said, "I'll only have one or two, because I really need it. It will just be to get it out of my system and then I won't have any more. I really need just one or two. After that, I can be a good mum to my kids".

Rosie raised an interesting issue in relation to coming off drugs in the prison environment as opposed to attempting to do it in the community. She said that in the community, the people she associated with were fellow drug users and there was little support or motivation to withdraw from substances. Nearly all her family were addicts and involved in crime. In prison, she met many women who were in a similar position to her, in that family and peer associations made it too difficult to desist, and even the threat of losing their children was less powerful than the addiction itself. In prison, "I had no choice. I had to stop". Rosie said that the other women "get it" and they support and talk to one another about it.

Best et al. (2015) point out that the overrepresentation of people with cognitive disabilities with drug and alcohol disorders needs to be viewed in the context of social exclusion. For women such as Mary, whose cognitive disability was attributable to drug use, critical skills that support independent and safe living were compromised. This included the capacity to set goals, be proactive in trying to achieve them and remaining motivated even when there were setbacks (Oscar-Berman and Marinkovic 2007). For Mary, among others (e.g., Amelia), staying off drugs was only possible in the highly structured prison environment.

Buchanan (2004) believes that social exclusion is the greatest obstacle to recovery from substance use, yet its impacts are not widely acknowledged by professionals, who are more intent on 'curing the disease' rather than addressing social factors that inhibit recovery (also see Best et al. 2015; Cole et al. 2011). Susan's observation that she had to be incarcerated to receive

help reflected the situation for the majority of the study's participants. Somewhat ironically, in terms of substance misuse, prison was less exclusionary for this group of women than when they were living in the wider community.

5.5.2 Health and mental disorders

The increasing numbers of incarcerated women with mental health disorders has been described by various authors as the 'criminalisation of mental illness' (Baillargeon et al. 2010; Blevins and Soderstrom 2015; Koons-Witt and Crittenden 2018). In the debates surrounding deinstitutionalisation, women have historically been overrepresented in mental health facilities and underrepresented in prisons (Crittenden and Koons-Witt 2017; Houser et al. 2012; Koons-Witt and Crittenden 2018; Sung et al. 2010). However, in Australia, there is now a substantial increase in the number of women with cognitive and mental health disorders who are criminalised (Human Rights Watch 2018).

Molly suffered serious and ongoing mental health disorders. The psychologist said that Molly was released from prison in September 2015, only to be returned immediately when she was observed in the prison carpark by a custodial officer "acting strange" and "cutting her hair in the carpark". During her interview for this study, much of Molly's speech was rambling, disjointed and incoherent. She was agitated at times, especially when talking about the fact that she had difficulty remembering. "What I just told you, I won't remember it a minute from now". Several times Molly said, "my brain's fried". She was placed in the Mental Health Unit on a number of occasions, where she was medicated. She believed that this "fried my brain". References to the Mental Health Unit were frequent. She said, 'when I was there, I woke up with worms in my hair. Thousands of them'. She had spent time in psychiatric units prior to coming to prison. While not diminishing the impact of mental illness on the other women in this study, Molly's interview was one that raised concerns about the incarceration of a cognitively disabled woman with such pronounced mental health disorders. She was bewildered and agitated and repeated several times, "I just want you tell someone [on the outside] about me. Can they come and get me?"

The prison psychologist said that Molly often constructed bizarre narratives. For example, when the psychologist asked her, "do you sleep?" she responded by saying, "there's a hole in the sky and a ladder and a man and kittens. She climbs up to the hole to stay with the man and the kittens". Molly's explanations were often confused, for example, "I wouldn't kill myself, but I do want to be in Heaven with Mummy. I love my Mummy". Molly said that she had three daughters and that the girls "are with my Mummy". She said, "Mummy stabbed the guy who

raped me". She also said, "Mummy's coming to prison". Molly was on 30-minute observations in the prison's Secure Unit and had again been referred to the Mental Health Unit.

Belinda's mental health was affected by drug and alcohol addiction from an early age and by the suicide of her sister. She was diagnosed with schizophrenia and was on a treatment order through the Mental Health Tribunal, receiving fortnightly injections. An issue for Belinda when in the community was a lack of compliance with taking prescribed medication, leading to an escalation in the severity of her mental health disorders and challenging behaviours. This resulted in police interventions, generally ending with a return to prison. Jennifer also had complex mental health problems arising from a trauma-filled past. Like Belinda, she was deeply affected by the suicide of her father. She had little emotional regulation which consistently manifested as rage. The prison psychologist made progress with opening communication channels by capitalising on Jennifer's love of animals. The psychologist used picture cards of animals, sliding them under the door of Jennifer's cell. The pictures helped settle Jennifer and eventually encouraged her to talk about herself. When speaking about the severity of Jennifer's mental health problems, the ALO said that because of the number of women affected by mental health disorders, it was impossible to address the problem in any substantive way, and so the prison policy was one of "don't open a can of worms", meaning that Jennifer did not receive the support she needed. Her behaviour was 'managed' through prison protocols, but there were insufficient resources to provide the level of intervention that might help her. The prison psychologist believed that Jennifer's life was unlikely to change. For any significant modification, she would have to address past trauma, which was too difficult to do in the prison setting. The ALO said, "She'll die. She'll be dead before she's thirty".

Ruth had drug-induced, psychotic-based mental health issues. She was a client of the Mental Health Unit both in and out of prison and was diagnosed with schizophrenia. Susan was diagnosed with BD. She was on mood stabilisers which she felt were working well. She said, "When I'm on the medication I feel like a normal person. I can wake up happy". Noelene was incarcerated in the Mental Health Unit on 15-minute observations. She was on a drug regime to help keep her settled. She was diagnosed with BPD and had many psychological interventions. Her recall was affected by her long-term drug use. She said that if someone read her a story, she could not remember it, even immediately afterwards. Melanie's mental health was compromised by the removal of her children to foster care. She said, "I can't eat, I can't sleep. I just cry most of the time". Erica, the study's youngest participant, said several times, "I'm mental". It was not clear if this is what other prisoners have told her, or if this is how she saw herself.

Safe and detention units are governed by security regulations, which are prioritised over meaningful mental health interventions. During this research process, observation of protocols in the solitary confinement units revealed the limited and often cursory nature of psychologist–prisoner interactions. Cell doors remained closed, with communication taking place through a letterbox-type slit opened by the psychologist. Conversations ran along standardised lines of "How are you? Any thoughts of suicide or self-harm?" with checkboxes ticked accordingly. These interactions were not private and could be heard by other women and custodial officers.

Practitioners indicated that mental health was an all-pervasive problem. Psychologists said that, overall, the prison system was under-resourced to adequately address issues of mental health that impacted the women's ability to live safely and independently in the community. The ODM from TWCC provided this observation, which contributes to understandings of social exclusion, inside and outside the prison setting:

> When some of the women are in the community, fear is a two-way street: people avoid interacting with them, but the way in which some of the women behave in public feeds community trepidation. This leads to misunderstanding on both sides.

Transfers to the prison Mental Health Unit were not readily available. There were long waiting lists, so even if a person was transferred there, it would only be for 24-48 hours. In reference to the Wilfred Lopes Secure Mental Health Facility, which is part of Hobart's Risdon Prison Complex, Psychologist 1 said, "we've never been able to send a self-harmer to Wilfred Lopes. We've successfully sent three people in the last 12 months there, and there's a wait list of four or five that haven't been sent". The interview with a BWCC psychologist elicited similar comments. At the time (December 2017), there were 141 women prisoners with mental health problems, 45 awaiting assessment and six severely mentally ill prisoners waiting for a hospital bed, including Noelene. However, the prison psychologist was not optimistic about (1) when that might happen and (2) how productive it would be. It was likely Noelene would be given a bed for two days at the most, insufficient time to effect any real change. She would then be transferred straight back to the prison's Safety Unit. The BWCC psychology team initiated several plans for Noelene, especially to reduce her violence towards others. However, part of the complexity of doing one-to-one activities, such as drawing or card games, pertained to the functional aspect of the prison. For these sessions to occur, she needed to be escorted from her cell in the Safe Unit with at least two custodial officers, which meant that those officers could no longer be on the floor, and so the rest of the unit had to go into lockdown. While practitioners acknowledged the merits of time spent with her, the reality was that it caused disruption to the

unit as a whole and could potentially 'back-fire' in other ways, such as prisoner resentment towards her because of their additional confinement.

Prison practitioners also spoke about addressing associated issues of trauma-related offending, which affected many of the study's participants. As one psychologist highlighted:

> She had never offended until three years ago, when she was raped. Then unfortunately, following that, she started to drink, started to get herself into trouble with the police. When she's really distressed, you can't stop her. Her arms and legs are flailing everywhere, she's yelling and screaming, she's saying "get away from me". I think inherently she's frightened, but it comes out in this massive outburst (Psychologist 1 MHWP).

Without exception, practitioners acknowledged the inappropriateness of prison as a place to address trauma that in many cases had done irreparable damage, sometimes physically, always mentally. As the psychologist from TWCC said, "a maximum-security environment doesn't do wonders for someone with trauma, you know". All participating practitioners recognised that the vulnerability of the women in this study outside of the prison was a significant issue, particularly in domestic violence situations. The ODM from AWP commented, "I see cognitively impaired women in here who have been particularly manipulated in very domestically violent relationships".

The TWCC psychologist spoke about Jennifer, who was accommodated predominantly in isolation in the prison's Secure Unit. As detailed in Chapter 4, Jennifer endured domestic violence that left her with significant physical injuries, and psychological and emotional damage from which recovery, particularly in the prison environment, was unlikely. Her frequent outbursts, manifesting as physical and verbal abuse of custodial officers, were understood in the context of traumatic history, but still attracted in-prison penalties of Secure Unit accommodation. The psychologist said:

> It's confusing, or surprising. I'll read case-notes, before I go over, and it's like she's done a mad rant at everyone, been tasered and all sorts of stuff, and then you go in, just wants to talk, and let it all out.

While this level of distress is also experienced by incarcerated women who do not have a cognitive disability, prison practitioners indicated for women who do, a lack of comprehension of prison rules and poor impulse control often resulted in challenging behaviours leading to greater use of accommodation in safety and detention units. As the BWCC psychologist said, "we need to come up with a better idea. S4 [Safety Unit] is not therapeutic at all. It is nothing more than containment".

5.5.3 Mental health and self-harm

It is prison protocol that, regardless of the security rating of prisoners and where they are housed within the prison, expressions of self-harm require their transfer to either the Mental Health Unit if there is space available, or to a Secure Unit. As identified by a range of scholars, organisations and prison psychologists themselves, the isolation cells for women who have self-harm or expressed thoughts of self-harming exacerbate existing mental health disorders with additional negative impacts because of the very things integral to the cell: isolation, 24/7 CCTV monitoring and 24/7 lighting (Human Rights Watch 2018; Moore and Scraton 2014; Senior and Shaw 2008). As several psychologists pointed out, despite being in a Secure Unit, women find ways in which to self-harm via objects as small as a paint chip scratched off the cell wall. While 'mental health' and 'self-harm' are closely aligned, this dissertation presents two separate discussions because several of the interviewees who had mental health disorders did not engage in self-harm, such as Belinda, Sally and Ruth.

Alice was accommodated in the secure Mental Health Unit on 15-minute observations. She was heavily scarred on her arms, legs and neck due to self-harming. The psychologist said that Alice had self-harmed every day of the fortnight preceding the interview. Bronwyn revealed that she self-harmed when kept in a cell by herself. She covered the cameras in blood. Caroline was committed to a psychiatric hospital on several occasions for chronic depression which found expression in acts of self-harm.

Jennifer's self-harm was a manifestation of the historical circumstances in which she experienced not only her father's suicide, but extreme physical and sexual abuse at the hands of family members. As Brown and Beail (2009: 510) state, "traumatic past experiences are alive in the present and hold meaning in relation to self-harm". Jennifer was severely scarred on her arms, legs, neck and chest from acute self-harming and her scars were the result of extremely deep cutting. Marzano et al. (2011) also contend that being transferred to another prison is often a catalyst for self-harm. This was also a factor in Jennifer's self-harming behaviours. The psychologist stated that because of the severity of her mental health disorders and her violence, Jennifer was routinely transferred between prisons to provide respite to prison staff. Each transfer prompted self-harming behaviours, so no matter which prison she was in, Jennifer was accommodated in solitary confinement.

Noelene persistently self-harmed. Her legs and arms were profoundly scarred. The psychologist said that Noelene managed to hide any objects she found in orifices or deep cuts she had made. Immediately prior to her interview Noelene had to be given a fresh suicide gown. She found a

miniscule piece of glass, possibly brought in via the tread of a tradesman's boot when he had come to repair light fittings smashed by one of the women. Noelene used this to cut her wrists. She was cleaned up, bandaged up and sent outside to do the interview.

Georgina was also a chronic self-harmer, with thickened scarring to her arms, legs and neck. She was adamant that self-harming brought her 'happiness', raising the question of how she could be effectively treated in the prison setting. She said, "I don't want things to change. I want them to get worse. I want to disfigure myself permanently so that people won't change me". Georgina saw her interview as an opportunity to talk extensively about self-harming and was primarily focused on describing the ways in which she could harm herself and how she had done this in the past. The psychologist commented that if Georgina observed other prisoners receiving extra attention because of the way they were behaving, particularly if it related to self-harming, Georgina's response was to wildly click her fingers above her head, jump naked on and off her bed, or to self-harm by hitting her head on the cell walls or floor.

Various scholars draw attention to cognitive disability (e.g., Arron et al. 2011; van den Bogaard et al. 2018) and psychiatric conditions such as BPD, BD and depression as compounding factors in cases of self-harming behaviour (e.g., Joyce et al. 2010; Zanarini et al. 2008). Van den Bogaard et al. (2018) note that limited communication skills associated with cognitive disability is a significant factor in cases of self-harm (also see Shannon 2016). Brown and Beail (2009) express a similar view, arguing that self-harm among prisoners with cognitive disabilities arises from their powerlessness in a very controlled environment, especially in relation to other prisoners who may not experience the same level of frustration associated with compromised communication skills (also see Oliver and Richards 2010). Within the group of women in this study who self-harmed, this aspect was identified by prison psychologists as a challenge they faced in attempting to talk to the women, for example, Jennifer, where communication relied on the use of animal picture cards placed under her cell door.

Practitioner narratives, and particularly those of the women, illustrate the links between mental health and exclusion in the prison. Mental health and self-harm did not improve in the prison setting; in fact, in many cases, the women's state of health worsened. This was especially true for those women in solitary confinement in safety units, which prompted an escalation in self-harm, despite the aim of such accommodation being to prevent it altogether. Women with cognitive disabilities are significantly impacted by the exclusion of solitary confinement, with little opportunity for those on mandated pharmacological interventions to discuss what is happening to them. All prison practitioners acknowledged the unsuitability of prison, and safety units in particular, to address mental health disorders arising from trauma-filled pasts.

5.5.4 Health and physical disorders

Marmot (2010) argues that addressing the health needs of incarcerated people and providing access to appropriate healthcare prior to prison, in prison and post-prison would be effective mechanisms for reducing social exclusion. In Australia, access to Medicare and the Public Pharmaceutical Benefits scheme is revoked while in prison, which intensifies health inequalities already faced by the prison population (Anderson 2018; Kinner et al. 2012). Kinner et al. (2012: 535) point out that '"underinvestment in prison health services by some Australian jurisdictions means that prisoners miss out on some treatments and medications available to the wider community". Van den Bergh et al. (2011) maintain that prison health is very much a part of public health, evidenced by the fact that since 1995, the WHO has specifically acknowledged this through its Health in Prisons project.

In responding to questions about their physical health and access to medical treatment, study participants who requested to see a doctor or dentist expressed frustration with the application process and the often long delays between a request being lodged and being able to see a medical or dental practitioner. Mary said that while she had generally been healthy in prison, having to go on a waiting list for the dentist was problematic as she was very uncomfortable with a severe toothache but had to wait "until it was my turn". Susan commented that she had seen medical practitioners in prison but had to wait several weeks after putting in her request form. She said that she found it difficult to have to fill out forms for "every single thing". This was an issue identified by several women, for example, Amelia, Theresa, Kelsey and Belinda, whose limited literacy skills meant they were dependent on others to correctly complete the forms before submitting them. These circumstances highlighted the difficulties faced by women with cognitive disabilities in attempting to obtain healthcare that was more accessible to those less challenged by communication and literacy.

A few women said that they received treatment in prison that they had not been able to access in the community. Deidre was anorexic and bulimic when she came to prison, but at the time of interview was healthy. Susan also reported being healthier since coming to prison, mostly because her diet had improved, although she commented, "I'm sick to death of salads!" However, in general, the women's physical health mirrored the AIHW's (2018) *The Health of Australia's Prisoners* findings. Ten of the women interviewed for this study were, or had previously been, smokers. Smoking bans in Australian prisons meant that they were unable to smoke while incarcerated. Asthma was a noted condition for five of the women who identified as being a smoker, which reflects the AIHW's (2018) national findings for women prisoners where 22% of prisoners reported having asthma. Miriam also suffered from emphysema which

worsened after being incarcerated. The prison provided an oxygen concentrator to assist with her breathing at night.

Several of the women had broken bones that had not been appropriately or effectively treated. Amelia received two broken collarbones as a result of abuse by her husband. Both collarbones were misshapen, the left one particularly enlarged and deformed. Amelia's husband also broke her right arm which was left untreated. She said that it caused her constant pain. Two women (Molly and Ruth) were pregnant at the time of interview. In Molly's case, regular medications for mental health disorders had been adjusted because of this. Ruth was due to give birth three weeks after her interview and had remained healthy during her pregnancy.

Some of the women were obese and being treated for diabetes. Miriam was receiving daily medication for diabetes and blood pressure. She experienced joint inflammation for which she was given anti-inflammatory medication. Noelene was also significantly overweight and suffered from inflammation of her joints. Miriam, Rosie and Bronwyn talked about unhealthy food choices made while in prison, saying that in weekly 'buy-ups' they mostly purchased crisps and lollies. An associated issue that came to light during the research process was that of exercise. There is substantial evidence detailing the connection between physical exercise and physiological and psychological health (Blick et. al. 2015; Callaghan 2004; Carless and Douglas 2009; Cashin et al. 2008; Warburton et al. 2006). Additionally, Cashin et al. (2008) draw attention to the links between no physical activity and hopelessness, a feeling often experienced by those who lack control over their lives. Their research demonstrates that exercise is an important element of a multidimensional process to reduce the occurrence and severity of both physical and mental illness, findings supported by Salmon (2001) and Levy (2005). With the exception of Renata, who utilised the small amount of fitness equipment provided by the prison, none of the women said that physical exercise was part of their routine.

The narratives of the women and those of prison practitioners cast prison health in a predominantly negative light, despite several of the women identifying prison as responsible for successful substance withdrawal. Physical health was generally poor, although some women received treatment that they might not have accessed in the community. This domain brought to the fore the exclusionary nature of healthcare inside the prison, especially for women with cognitive disabilities who were mostly denied opportunities for discussing and understanding what was being done to them by way of treatment. The process for seeking medical treatment was also exclusionary because it relied on filling out forms, which was especially difficult for women with cognitive disabilities and low literacy levels.

5.6 Domain 11: Agency from the inside

Bosworth (1999: 30) argues that "the ability to be an agent is always under assault in prison, because prison undermines people's capacity for autonomy and disqualifies them from making decisions about how to conduct their own lives" (also see Nedelsky 1989). Bosworth (1999: 3) also points out that, agency in the prison setting "denotes the ability to negotiate power" (also see Rubin 2017; Sherwin 1998). Prisoners are clearly disadvantaged in such 'negotiations'—their movements are restricted, as are all other dimensions of agency, such as choice, independence and responsibility. For the women in this study, lack of agency was directly related to cognitive disability, whereby most aspects of their lives were managed to a far greater extent than women without a cognitive disability. Practitioners said that they viewed several of the women as being like children, for example, Bronwyn, Maddie, Caroline, Erica and Rachel, admitting that this was how they tended to treat them. Practitioners generally believed they were incapable of making good decisions about personal safety, especially those related to relationships, accommodation and substance use. And yet, in speaking with the women, what became evident was the way in which they had already functioned as agents, despite having limited opportunities or negligible belief in themselves. Somehow, they had navigated the worst possible situations. Even without a cognitive disability, all but the most resilient people would have been challenged by similar circumstances.

5.6.1 Agency and decision-making

For the women in this study, an absence of self-esteem generated the feeling that they were not empowered to make choices for themselves. Prison deprives those who are incarcerated of the ability to make decisions about almost every aspect of their lives. However, for women with cognitive disabilities, this is not a complete departure from circumstances outside of prison. In the community, social institutions such as health and education are not structured in a way that promotes agency and decision-making for those with compromised cognitive function (Warren 2015). This lack of agency is amplified in the prison setting, in which opportunities for input into aspects such as program participation, work or pre-release planning is substantially curtailed for women with cognitive disabilities, thus conceptualising ideas necessary for post-prison planning and reintegration is challenging.

Decision-making was generally restricted to circumstances beyond prison. Rachel was definite about what post-release would look like: "I don't want kids. I don't want a partner. I want a job and a house to live in. Those are the things I want". Theresa said she would have "everything in place when I get out. I'm going to see the psychiatrist and go to the [local Indigenous] medical

centre". Susan, who was due for release shortly after her interview, did not know where she was going to live. Her decisions about post-prison were only for the immediate future. She said, "I just want to have a good time at the weekend. I want to have some drinks". However, Susan had also made a decision with respect to the security guard she assaulted, resulting in her incarceration: "I want to find him and apologise to him".

Noelene's decisions revolved around in-prison therapeutics, in which she utilised strategies given to her by the psychologist. This involved visualisation techniques in which she imagined walking through a rainforest. Noelene said, "I decided to go to Mount Gravatt lookout in my mind. It was the place that made me happy. I imagine being there with my brother and my niece".

What was noticeable in speaking with the women was not just a dearth of decision-making, but also a lack of comprehension as to what 'decision-making' entailed, which the women's narratives consistently demonstrated.

5.6.2 Agency and goal setting

While all the women who participated in this study had their own inner strength, albeit suppressed and hidden in many cases, Deidre was an exemplar of what agency in prison could look like through setting goals (see Deidre's story in Appendix 7). Once incarcerated, Deidre demonstrated strength and determination in turning the tide of abuse, coercion, substance misuse and poor mental and physical health. For Deidre, agency in prison involved setting goals—to participate in programs, improve her security rating, to learn literacy, become substance free, address a chronic eating disorder, work, develop trust in others, and ask for help during times of stress and anxiety. Achieving these goals did not come quickly or easily. This was a four-year process in which Deidre experienced highs and lows. However, the psychologist said that Deidre's journey inspired other women to try and achieve a better outcome for themselves. For example, Kelsey, after a lifetime of illiteracy, realised that she too could learn educational skills. At the time of interview, she was participating in a maths course.

Bronwyn was working towards a better security rating. Her goal was to make it to medium security so that she could participate in programs and be allowed greater freedom to move around the prison. Theresa was also working towards an improved security rating because she wanted to work in the RSPCA program socialising stray cats and kittens. Improving their security rating was a goal for several other women. At the time of interview, Rosie had been transferred to the detention unit because she hit another prisoner, but she was very keen to be

returned to minimum security and so was trying to exercise impulse control to achieve this. The counsellor said, “so far, so good. She’ll probably be returned to Res (residential) next week”.

However, on the subject of goal setting beyond prison, Georgina said, “Do you really want to know? Do you want to hear my list? I’ve got six things on my list that I want to do”:

Georgina’s goals:

1) Become an alcoholic.

2) I want to go to my friend’s house, and I want him to hurt me. I’m going to say to him, “I’ll pay you money to cut my leg off”.

3) Die or end up in hospital.

4) End up back in gaol for killing someone.

5) Kidnapped after gaol.

6) Be a permanently mutilated person.

Georgina insisted on having the above list written down word for word and was adamant that it should be produced for others to read.

Sherwin (1998) highlights several of the factors applicable to this study’s participants. Limited material resources and education and an ongoing fear of physical harm from not only strangers but people known to them constitute significant restrictions to agency (also see Hall 2004). For these women, such restrictions were in place pre-prison, but the constraints of the prison environment ensured that any sense of agency was suppressed by the carceral experience, especially women with exceptionally compromised cognitive function such as Caroline, Maddie, Sally, Noelene and Molly.

Viewed collectively, the women’s narratives indicate that, similar to their ideas expressed in Chapter 4, goal setting, much like decision-making, was considered in a narrow context, with goals related to improved security ratings dominant. Not all the women engaged in goal setting. Some were unsure as to what ‘setting goals’ meant and it was clear that it was not something that had ever been discussed with them. This applied particularly to women with comorbid mental health conditions, such as Sally, Molly, Jennifer and Ruth who did not respond to questions about setting goals despite the concept being explained to them.

5.6.3 Agency and life skills

The majority of the women had very poor living skills, something that impacted their lives pre-incarceration, but was also apparent in the prison setting. Most had little ability to reason or problem solve, or to anticipate the consequences of their actions or things that they said. These skills were acknowledged by prison practitioners as those which most influenced the women's vulnerability and susceptibility to coercion by other women. Additionally, basic life skills, such as taking care of themselves (e.g., personal hygiene and asking for help to organise medical or dental appointments) were issues that several women were working on. Prison practitioners were in agreement that with respect to adaptive behaviours, women with cognitive disabilities were able to complete tasks that were known and familiar, such as making their bed, cleaning wet areas, or particular kitchen tasks which they learned through repetition. However, skills requiring a more abstract level of understanding, such as being able to evaluate peer connections leading to unsafe outcomes, were less evident (see Salekin et al. 2010).

A small minority of women commented that they had learned skills that would help them when they left prison. Rosie said that she could use the money she previously spent on ice to pay for "a house for myself and my daughter". Melanie planned to use what she had learnt doing 'parks and gardens' duties at the prison to obtain employment when she was released, "so I can buy my kids toys and clothes". However, Sally and Miriam, among others, were constantly targeted by other prisoners because of poor personal hygiene and an inability to care for themselves. This resulted in their exclusion and marginalisation within the prison, as the other women distanced themselves from them.

Overall, practitioners regarded the acquisition of these skills to be as important as criminogenic and therapeutic programs, and yet there was little capacity within the prison to teach them. The ALO from TWCC said, "I don't think we're really doing anything to help at the moment, in terms of them [cognitively disabled women] being able to be better skilled out there. We're just kind of helping them manage in here". The ALO from AWP echoed this sentiment: "Even if we do have some supported care, I think it needs to be the whole person - education, employment and recreation, and daily living skills". In response to questions regarding the acquisition of life skills, Psychologist 2 from MHWP summarised the situation by referencing the fact that prison did not provide the type of supports needed for the women to live safely in the community:

> It would be great to see programs on a rolling basis - life skills, like independent living skills. We don't offer much of that in here, and I think that if we can arm them with the skills to actually survive out in the community, there would be huge gains.

> Budgeting, getting public transport – I'd love to be able to see them eligible for more supports, so that that stuff could be done while they're in prison, rather than having to wait for them to get out, and back into their chaotic world that they live in.

These narratives provide views from practitioners (who are closely involved with the women) that life skills is an area of concern and that their absence contributes to the chaotic lives of some of the women. Of all the interventions proffered by practitioners that could occur in prison, the acquisition of life skills was identified as essential, and yet it remained something that none of the participating prisons were (at the time of interview) delivering.

5.7 Domain 12: Civic engagement on the inside

As noted in Chapter 3, if 'civic engagement' is considered as opportunities for input into one's own environment and circumstances (Lafferty et al. 2016), the prison is not a setting in which this can realistically take place. This domain illustrates the extremely limited opportunities for the women in this study to contribute to, and participate in, any activities that might be considered civic engagement inside the prison. Prison work was regarded by some of the women as positively contributing to their community. Care of others was even more limited, with concern for other women in their units the main outlet for this. Participation in this research project could be thought of as 'civic engagement', especially given the broader potential for the women's narratives to generate discussions regarding the incarceration of cognitively disabled women.

5.7.1 Civic engagement and community participation

'Community participation' is not something generally associated with the prison environment, but there are examples that can be used to demonstrate its existence. Melnick et al. (2001) highlight the way in which participation in education, work and activities such as prison playgroups, mirror social and interpersonal activities in the community. Several of the women who worked in prison viewed their role as something more than just an avenue for earning extra money. Belinda was a bin-runner during previous custodial episodes and was employed in this role at the time of interview. She was proud of what she achieved from two perspectives. First, she was very good at the job, and the prison staff regularly told her this, which positively impacted her confidence and sense of self-worth. Second, she said, "I make the place look good. It looks better because I do my job". Melanie, who was on 'parks and gardens' duties enjoyed her work and took pride in the results of her efforts, which were apparent from the well-maintained lawns and garden areas of the prison. She said, "I like doing this work. It makes it nice for all the other girls".

An area that could be considered ‘civic participation’ was the women’s decision to take part in this research project. Explanations of the purpose of the research indicated that their stories would be read by other people, some of whom could use this knowledge to make aspects of prison life better. Alice said several times, “I just want my story told”. They understood that participation did not necessarily mean their own lives would change in the short term, but in all cases, the notion that they had the power to help make a difference was, to them, inspirational.

5.7.2 Civic engagement and care of others

‘Care of others’ was limited. Volunteering in prison requires a particular security status, which most of the women did not have. Some of the women, such as Theresa, Amelia and Rosie, expressed a desire to volunteer, particularly for RSPCA work. Stearns et al. (2018: 408) argue that for incarcerated women, the act of volunteering aides in “social connectedness and their feelings of value and self-worth” (also see Heidermann et al. 2016). Care of others was mostly limited to women accommodated in minimum security who befriended women needing support. Rosie was a prominent ambassador for care of others, saying, “I know what it’s like to be treated like shit. Lots of the girls here have been treated like shit. We help each other”. However, cognitive disability impacted ‘care of others’ on several different levels. Prison practitioners pointed out that some of the women did not understand when someone else was upset and needed to be left alone, leading to tensions when study participants continually wanted to talk to them and to know what was bothering them. Additionally, other prisoners sometimes found it difficult to engage in conversation with women with cognitive disabilities, with one practitioner commenting that some of the women participants “get used to being told to piss off”.

The paucity of examples for Domain 12 (civic engagement) highlights an area of concern. Melnick et al.’s (2001) evaluation of civic engagement in the prison setting emphasises its importance, with the engagement in pro-social activities that reflect those in the community. In speaking with the women, an impression was their desire to ‘do something’. They may not have articulated what ‘doing something’ entailed, but with only a few exceptions, such as Jennifer, Maddie, Caroline and Georgina who were on drug regimens and unable to think in a more abstract way, the other women all expressed a desire to be involved in a way that was helpful to others, either by volunteering or being a friend to someone in need. One of the most noticeable attributes of most of the women was their sense of kindness, which seemed to be an excellent starting point for providing opportunities for ‘civic engagement’.

5.8 Conclusion

This chapter explored the notion of social exclusion in the prison environment and how the women in this study, through institutional protocols and practices, were excluded in a space that, by its very nature, represents the ultimate form of social exclusion. As Chapter 4 identified, cognitive disability impacted most areas of the women's lives when they lived in the community. Chapter 5 provided evidence that prison did not change this and in fact, the cloistered nature of the prison environment and the lack of spaces in which to escape bullying and coercion were amplified in this setting.

Domain 7 (informal networks on the inside) highlighted the fracturing of relationships because of incarceration. With the exception of Melanie and Renata, none of the women had visits with their children. While some spoke to them on the phone, others had not seen their children for several years. This domain also revealed the influence of peers within the prison and how, for many of the women, bullying and coercion dominated these connections. This was an area in which cognitive disability was apparent. An inability to be discerning with personal information that could potentially be used against them, as well as a desire for acceptance leading to rule-breaking behaviours, saw several of the women viewed by others as 'easy targets'.

Domain 8 (formal networks on the inside) examined the role of CPS and the CJS. Of the 15 women in the study who were mothers, 10 had children who were under the direction of CPS. Most did not expect to regain custody of their children, although this remained one of their goals. Information from CPS about their children was inconsistent, with some women receiving no updates at all. With respect to the CJS, court appearances via video link were a source of anxiety and confusion for many women. Prison reception was generally viewed as confronting. Women on remand were at heightened risk for self-harm and compromised mental health. Program participation was limited. None of the women had been involved in a domestic violence program, despite being victims. A small minority had participated in substance abuse programs. Those in secure or detention units were not permitted to attend programs. Only a small number of women had a prison job.

Domain 9 (trust and safety on the inside) provided insights into the women's perceptions of how safe they felt within the prison setting. Although some women believed that prison was an unsafe space to be in, with very few people who could be trusted, there were others who felt safe and had a number of trusting relationships with both staff and other women prisoners. All women trusted professional staff, but not all prison officers. Cognitive disability was a significant factor in the evaluation of this domain. Misplaced trust, a lack of understanding as

to appropriate information to disclose, and an inability to interpret reactions and emotions of others, sometimes resulted in bullying and altercations.

Domain 10 (health and wellbeing on the inside) revealed that the health of the women participants reflected the broader conclusions reached by the AIHW's (2018) *The Health of Australia's Prisoners*, which draws attention to the poorer physical and mental health of Australian prisoners in comparison with the general community as well as elevated rates of substance misuse disorders. Cognitive disability was again a significant factor, particularly for women on drug regimes, about which they expressed minimal understanding. Overall, the women's physical health was poor, with conditions such as obesity, diabetes, cardiovascular disease, respiratory illnesses and arthritis affecting several participants. The health of a few participants improved in prison, mostly due to coming off substances, but in general, prison itself contributed to a decline in health and wellbeing.

Domain 11 (agency on the inside) investigated a concept not generally associated with life in prison. Decision-making, goal setting and life skills were three areas that could be considered part of being an 'agent'. For the women in this study, opportunities to make decisions or to set goals were extremely sparse. Prison practitioners noted that cognitive disability impacted these areas, especially for women who they regarded as childlike, with little capacity to make safe decisions.

Domain 12 (civic engagement on the inside), like Domain 11, was also extremely limited. Some of the women regarded their jobs as civic engagement in that they viewed what they did as helpful to the prison 'community'. Research participation could also be considered civic engagement, especially in the light of the potential for the women's narratives to generate changes for women offenders with cognitively disabilities.

The women's lived experiences provide insight into prison experiences such as their relationships with other prisoners, particularly their vulnerability to coercion and bullying. The role of CPS during the women's custodial episodes, court appearances from prison via video link, being remanded in custody, and prison reception procedures demonstrate the sense of confusion around institutional processes that most of the women had difficulty understanding. While feeling unsafe and having few people they trusted reflected life outside prison, these feelings were intensified by the confines of the custodial setting. Issues of mental health and self-harm escalated for several of the women, heightened by historic and ongoing trauma. Lack of agency characterised the lives of most of the women prior to incarceration and was equally apparent inside prison. While women without cognitive disabilities could be active participants

in programs and pre-release planning, this type of agency was less accessible for cognitively disabled women. Civic engagement was negligible, although participation in this current research project could be considered as civic engagement.

The six domains discussed in this chapter focused on the ways in which social exclusion manifests in the prison setting for this group of women. It is an accepted fact that those who go to prison are socially excluded. What is less obvious, because it is less visible, is the manner in which social exclusion continues to infiltrate and impact the lives of those who are incarcerated. As Chapter 4 revealed, the women who contributed to this study have been socially excluded while living in the community. Chapter 5 demonstrated that prison offers them little in the way of relief; in fact, it takes the phenomenon of social exclusion and augments it by ensuring that cognitively disabled women have little or no input into any aspect of their lives. Additionally, while prisoners without a cognitive disability have capacity for program participation and, therefore, the potential to obtain parole, this is not something that cognitively disabled women can expect to achieve. Nevertheless, when considering the circumstances of this group of women and the way in which they have navigated immensely challenging terrains, it is reasonable to conclude that 'agency' and 'resilience' have contributed to surviving the journey.

Chapter 6: Cognitive Disability and Women's Prisons: A Nebulous Relationship

6.1 Introduction

The purpose of Chapter 6 is to provide evidence that responds to Research Question 3: How do prisons respond to the needs of women with cognitive disabilities? The chapter is prefaced with an acknowledgement that prisons generate and sustain social exclusion through institutional processes driven by tenets of security and containment. While rehabilitation is a stated objective of all Australian Corrective Services, prisons do not prioritise psychological support, therapy, or the development of adaptive skills, with rehabilitation subordinate to punishment and community safety.

In addition to evidence from the relevant literature, there is a prominent emphasis in this chapter on the professional observations and opinions of the study's participating practitioners. When considering these perspectives, a view of social exclusion emerges that highlights how central cognitive disability, mental health and challenging behaviours are to the way in which exclusion manifests in prison and also how the experiences of this group of women during incarceration provide little hope for inclusion post-prison.

This chapter examines three key areas: (1) the needs of the women in this study, (2) how the prison currently responds to those needs and (3) whether prisons address the women's needs. Evidence from prison practitioners indicates that for the women in this study, prison is unable to provide the type of support needed to improve crucial aspects of their lives, including (1) recognition/identification of cognitive disability, (2) mental health, (3) criminogenic needs, (4) adaptive skills, (5) family and community connections, (6) cultural sensitivities and (7) external support services. In general, the women in this study exit prison in much the same way as they entered, that is, with mental and physical health disorders, challenging behaviours, fractured family relationships, lack of adaptive and life skills, lack of agency and few opportunities for civic engagement. In addition to evidence arising from the literature, each of these needs were identified by practitioners from the participating prisons as central to not only improving the women's lives, but also generating holistic change with the potential to significantly reduce reoffending and interactions with the CJS.

As noted in Chapter 3, practitioners contributing to this study were psychologists, counsellors, ODMs and ALOs. These roles involved several interconnected elements. Interfacing with

prisoners formed a substantial component of practitioners' work, but this was multifarious. They were often tasked with attempting to solve insoluble problems, such as helping incarcerated women to address pre-existing and ongoing trauma in the prison setting, as well as managing women suffering in other ways, whether from bullying, loneliness, substance withdrawal, dislocation, estrangement or removal from family and/or community, loss of access to children, fear and confusion. Challenging work also meant traversing sometimes unrealistic workload demands, extremely high caseloads, lack of resources to service those caseloads, limited treatment options for prisoners' mental health and substance misuse disorders, and no appropriate accommodation and program options for women with cognitive disabilities.

The prisons involved in this research shared similar features related to personnel organisation. Staff teams had different remits: therapeutic services (psychological intervention and crisis support); programs; risk/needs assessment involving case coordination (sentence management and reintegration); parenting and family support; prisoner education and employment; recreation; ALOs (or Cultural Liaison Officers) who organised Elder visits; and counsellors who assisted with finance, Medicare, Centrelink and post-release accommodation. An Integrated Offender Management Unit coordinated these services. The views presented throughout this chapter are those of practitioners participating in this study and are not necessarily representative of personnel in other Australian prisons and jurisdictions.

Each interview started with questions such as "Tell me about your role and the work you do". Sometimes the response took the form of "do you want to know about what my job is meant to be, or the job that I actually do?" The use of 'appreciative inquiry' (Liebling et al. 1999) and 'strengths-based language' (Wormer 1999) did not always produce positive responses. Practitioners often struggled to pinpoint organisational and operational strengths, revealing a degree of immunity to the processes and time constraints that prevented them from doing their job in a way that fostered (in their view) 'exceptional' practice. This was evident in the use of language that was fundamentally problem laden or deficit oriented. While they acknowledged that overall they were doing a good job, they stressed that this was impacted by high caseloads and by the operation of the prison itself.

Prison practitioners spoke about their work in a straightforward way, which upon listening to them, might have been mistaken for detachment. This assumption would be wrong. The women they interact with each day are high needs, and cognitive disability adds an additional layer of complexity that practitioners are required to manage. Most admitted that they did this better on some days than others, but this admission spoke only to their humanity, not their lack of commitment. Prison practitioners work in one of the most artificial and difficult environments

imaginable. There is nothing in society that replicates 'the prison'. Every aspect is controlled and regulated. It is not a place in which spontaneity and joy are especially welcome. Kindness is often viewed with cynicism, compassion with derision. And yet these practitioners exhibited each of these attributes—not all the time, but at least some of the time. They managed to find occasions to be spontaneous and even joyful, to be consistently kind and compassionate in a place that does not always value either. The words of one practitioner were particularly insightful: "The prison is like a different planet. When I come to work, I'm coming to a different planet". With the priorities and obligations of prison practitioners in mind, the ensuing examination of the women's needs and current prison responses draws upon practitioner expertise, placing this knowledge in the context of the wider literature.

6.2 The women's needs and current prison responses

Chapters 1 and 2 demonstrated that, while there is broad acknowledgement of the needs of incarcerated males with cognitive disability, with therapeutic approaches operating in men's prisons, there is limited acknowledgement of the needs of incarcerated women with cognitive disabilities (Cockram 2005; Hayes 2007). With noted increases in rates of cognitive disability and comorbid conditions among the female prison population, especially Indigenous women (Rowe et al. 2020), this is an area that warrants the attention of the CJS generally and women's prisons in particular. The prisons involved in this study did not consistently collect or assess data on cognitive disability, and as psychologists noted, without accurate data, it is difficult to provide adequate and appropriate services and accommodation for cognitively disabled women.

As the following analysis reveals, prison practitioners, while recognising the needs of this group of women, were unable to respond in any substantive way because of competing demands. These included, for example, managing women with severe psychiatric conditions, the requirement to enforce prison regulations to maintain security, significant caseloads, and the fact that cognitive disability is not a high priority in the face of immediate and potentially life-threatening concerns such as self-harm and suicidal ideation. Chapters 4 and 5 highlighted the women's unique vulnerabilities, which are problematic to address in the prison environment despite being fundamental to reducing reoffending and promoting social inclusion. In many respects, the women's needs reflect the wider literature concerning women's incarceration and the incarceration of people with cognitive disabilities. These needs are examined with the understanding that it is not a definitive list. There are other needs that could be added to it. However, the needs identified here are those that practitioners regarded as germane to all women participants, with the exception of 'cultural sensitivities' applicable to the study's Indigenous women.

6.2.1 Need: Identifying cognitive disability

There is wide scholastic and CJS recognition that rates of cognitive disability in Australian prisons are high (e.g., ALRC 2017; AHRC 2014; Baldry 2017; Baldry et al. 2012; Brolan and Harley 2018; Cunneen et al. 2013; McCausland et al. 2013; Sharma 2018; Shepherd et al. 2017). As Rowe et al. (2017: 7) maintain:

> One of the consequences of the extreme social disadvantage experienced by this group is a lack of established diagnoses: for many, formal diagnosis of their disabilities does not occur prior to the age of 18; for a significant number, formal diagnosis occurs for the first time after entry into the criminal justice system.

Women with cognitive disabilities frequently do not have their disability accurately identified upon entry to prison or during the time they are incarcerated. Chapter 5 drew attention to the case of Mary, who answered 'yes' to the risk/needs assessment questions 'Do you receive the DSP (Disability Support Pension)?' and 'Do you think you're a slow learner?', thereby labelling her as having a cognitive disability despite the prison psychologist's scepticism that this accurately represented the nature of Mary's cognitive abilities. Furthermore, during a discussion of cognitive disability in the context of the CJS, one practitioner commented:

> I don't think the CJS has a very good understanding of intellectual disability and what that means. I think they see it probably much more black and white, as either they've got capacity or they don't have capacity, rather than seeing, I guess, all the nuances and the individual differences and contributing factors (Psychologist TWCC).

This position is also supported in the wider literature. The AHRC (2014: 28) maintains that, "assessment for disability in prison is patchy and not consistently measured". Additionally, Brolan and Harley (2018) highlight the lack of recognition of cognitive disability among Indigenous prisoners, largely due to modes of testing that are culturally biased against minority groups (also see Balaratnasingam and Roy 2015; Roy and Balaratnasingam 2014). Young et al. (2016) maintain that the lack of formal diagnosis of individuals with cognitive disability makes it difficult for prison personnel who have not had specific training in disability services to recognise and/or understand situations involving prisoners with cognitive disabilities.

6.2.2 Current prison responses to identify cognitive disability

In terms of the present study, prison responses to the identification of cognitive disability varied. Psychologists involved in this study were reticent to rely on IQ testing (e.g., the Wechsler Adult Intelligence Scale) as a definitive measure of cognitive disability. Practitioners in each of the participating prisons emphasised the presence of mental health and substance misuse disorders as a key factor in shaping inconsistent and unreliable IQ outcomes. Fluctuating results were

associated with the type of day the participant was having, when/if prescribed medication had been taken, whether they had experienced conflict with other women or prison staff, and their general level of compliance at the time. Psychologists also believed that for many of the women in this study, administering tests had the potential to create further distress. As noted in Chapter 5, attempting to administer the IQ test with Jennifer was problematic and ran the risk of further undermining her mental health. As the TWCC psychologist suggested:

> It is very difficult to test her cognitive ability using WASI [Wechsler Abbreviated Scale of Intelligence] as she is never in the right space to do it. She says it makes her "feel dumb". To be honest, the scores would add nothing of value to her life.

Over and above intermittent use of IQ testing, there was inconsistent use of the HASI test, which incorporates an assessment of adaptive skills. There were different reasons given for this, for example, not having the time to administer the test, or a reluctance to use the test because staff did not find it particularly helpful. In discussing whether women came to prison with a definitive diagnosis of cognitive/intellectual disability, most practitioners indicated that unless a diagnosis had been established by an outside agency, such as Disability Services or a doctor, the prison generally did not spend time in finding out about the nature of the disability. Administering IQ tests or HASI were regarded as time consuming, with minimal value in terms of prisoner management attached to their scores. Even if one or both tests identified the presence of a cognitive disability, with no specialist services in place, prison approaches did not vary significantly from those directed towards women without a cognitive disability. When asked whether the prison sought information about the specific nature of any cognitive disabilities identified at the time of prison reception, a psychologist from MHWP commented that she only became aware of the exact diagnosis of Deidre's disability through indirect means:

> The only reason I know that she has a genetic issue is because CPS contacted us to get some blood samples from her, to check the child, but she didn't get feedback necessarily about that. They just said, "Can we have your blood? Thanks for that, and yes, it's confirmed. You and he have the same issue (Psychologist 2 MHWP).

In Theresa's case, she entered prison with a previously diagnosed cognitive disability, which she was very precise in articulating. She said:

> I know exactly what's wrong with me. The doctor told me, and I learnt if off by heart. My daughter's got exactly the same thing wrong with her too. Do you want to know what's wrong with me? I've got a translocation of chromosomes 2 and 22. My son also had it, but he died.

However, knowledge of Theresa's diagnosis had little impact in the prison setting, where she was accommodated predominantly in the prison's detention unit in response to her challenging behaviours.

There are a number of key considerations arising from practitioner input and the broader literature. The first is the lack of diagnosis of cognitively disabled women entering prison, particularly when assessments are based on limited questions in a risk/needs assessment that may be open to interpretation by both the prison staff asking them and the women answering them. Asking the women 'Do you think you are slow learner?' is subjective and does not provide robust evidence of a disability. Second, regardless of whether the presence of a cognitive disability is established, prisons do not have established protocols to manage this situation differently to any other prison entrant, leaving cognitively disabled women open to exclusion within the prison setting and beyond through lack of appropriate interventions to develop skill sets, for example, adaptive skills.

6.2.3 Need: Psychiatric wellbeing

Each of the women in this study entered prison with a mental health disorder. As Chapter 4 identified, the vast majority of participants had histories of trauma and co-occurring substance misuse disorders. However, as Dean et al. (2013) identify, there are no consistent models or guidelines for mental health screening for women entering prison, which results in many psychiatric disorders being missed. For the women who are undiagnosed, the stress of incarceration often leads to a worsening of symptoms or the development of additional conditions such as depression. Rowe et al. (2017: 13) argue that, "it is widely acknowledged that, premised as they are on punishment and risk management, criminal justice systems are not well-equipped to respond to the unmet disability-related complex needs of the high proportion of persons in their care who have cognitive and mental health impairments (also see McCausland and Baldry 2017).

For the women in this study, the presence of cognitive disability added complexity in terms of psychiatric care and wellbeing. Cognitive disability, particularly in the prison setting, may result in difficulties with controlling emotional and behavioural reactions, with impaired cognition and understanding having serious consequences in an environment governed by rules and regulations (Haney 2002; QAI 2016). As noted earlier, Theresa spent all her time in the prison's detention unit as her lack of emotional regulation manifested as violence towards custodial staff and the damage of prison property. These behaviours were repeated over and over, but Theresa received no interventions that addressed the reasons for these behaviours.

Bronwyn was accommodated in MHWP's maximum security wing for similar reasons. Prison psychologists acknowledged the futility of this, citing the conditions of solitary confinement as instrumental in generating Bronwyn's behaviours. However, security concerns and the requirement to address Bronwyn's actions via solitary confinement took precedence over therapeutic interventions.

6.2.4 Current prison responses to psychiatric wellbeing

Providing psychiatric and mental health care in prisons is challenging in that prisons are essentially an anti-therapeutic space. Mental health and psychiatric service provision in prisons is demanding, and problems are often addressed by the use of medication, mainly because there are few intensive psychiatric and counselling services for women who have deep trauma (Dean et al. 2013). In the participating prisons, the management of women with mental health disorders was undertaken by custodial staff who had only limited training in managing mental illness and did not have complete access to information regarding the person's needs. In general, the approach was not treatment based; rather it is focused on supervision and monitoring to avoid instances of self-harm or the endangerment of others, as the examples of Theresa and Bronwyn highlighted.

Women with a short custodial sentence (i.e., shorter than three months) were generally ineligible for therapeutic services. For those on remand, it was at the discretion of the prison, as a psychologist from MHWP highlighted:

> At the moment Bronwyn's seeing therapeutics, so because she's under risk assessment process at the moment, we are seeing her twice a week. I'm not generally supposed to, but we just need to put that into her, because she needs support (Psychologist 1 MHWP).

Mentally ill women have extremely limited opportunities for accessing a psychiatrist, even with a recognised psychiatric condition. For example, Theresa entered prison having been under the care of psychiatrists in both Gympie and Ipswich, where she was being treated for kleptomania, depression, anxiety and bulimia. In the prison setting, her conditions were managed through accommodation in the Safety Unit, although at the time of interview she was housed in the detention unit, having incurred over 30 breaches of prison regulations in less than nine months. During her nine custodial episodes, Theresa had never been accommodated in Residential (low security). The BWCC psychologist commented that it was a complex situation because Theresa hated being in solitary confinement and so she damaged the cameras, leading to charges of wilful damage and even more time in isolation. Theresa continually vented her frustration on custodial officers, and at the time of interview, she was cited for 10 counts of serious assault of

custodial officers with further charges pending. As the psychologist said, In her [Theresa's] case, you can see all the reasons why she does what she does, but we're not in position to give her the help she needs. We just manage her behaviours, and don't really get to her core issues.

In Queensland (QLD), the average time to see a psychiatrist was two to three months. As Chapter 5 identified, even with multiple referrals to forensic mental health services, severely mentally ill women had little chance of being given a bed in a forensic hospital, which had extensive waiting lists. According to the psychologist from BWCC, if a bed was secured, it was only for a maximum of two to three days. As Rowe et al. (2017) point out, the presence of a cognitive disability is itself an issue, because the women may not be responsive to medication or other therapeutic interventions in the same way as someone who has a mental health condition, but no cognitive disability, might possibly be. When speaking about this, a psychologist from MHWP remarked:

> We find it very, very hard to even get a psychiatrist to review someone with an intellectual disability, unless they're sectioned under the *Mental Health Act,* or sentenced as not guilty by reason of insanity. People like Bronwyn don't even meet the grade. She doesn't get forensic mental health support on the outside, because she doesn't meet their criteria (Psychologist 1 MHWP).

In all participating prisons, the use of safety units for women with mental health conditions, including self-harming behaviours, was prevalent. These units house women in maximum security arrangements, in solitary confinement, monitored via CCTV and 15- to 30-minute observations by custodial staff. As Chapter 5 highlighted, the women were visited by the psychologist generally, though not always, once a day, with standardised questions such as '"any thoughts of suicide today?", the responses to which could be overheard by the other women in the unit and custodial staff. The women in this study typically spent 22 hours a day inside these cells, with little or no social contact with others. Human Rights Watch (2018) noted that women with cognitive disabilities in Queensland's women's prisons were especially overrepresented in solitary cells, in part because they were considered a 'management issue' rather than as suffering from mental illness.

At the time this study was conducted, the safe, or observation, cells in BWCC were full due to the high number of women who were self-harming and/or on suicide watch. In the absence of effective mental health and psychiatric services, this type of accommodation was used to keep women safe, but practitioners commented that in general it was a highly debilitating environment. As the psychologist from TWCC said, "a maximum-security environment doesn't do wonders for someone with trauma…", a sentiment echoed by the BWCC psychologist who

said, “we need to come up with a better idea. S4 [Safety Unit] is not therapeutic at all. It is nothing more than containment”.

Pharmacological interventions were also used in response to mental health disorders such as depression, anxiety, post-traumatic stress disorder (PTSD) and psychosis. For example, the ODM from AWP said that Caroline and Maddie were administered sedatives to help keep them settled. The TWCC revealed that Belinda, Ruth, Molly and Jennifer were also receiving pharmacological interventions involving sedation and medication to reduce psychotic episodes, although as Chapter 5 noted, drug regimens for Molly and Ruth had been altered because of their pregnancies. All participating psychologists remarked on prison responses to the study’s women who suffered psychiatric disorders, noting the lack of capacity for prisons to offer effective interventions that went beyond simply isolating them.

6.2.5 Need: Criminogenic needs

In their discussion of criminogenic needs, Andrews and Bonta (1998) describe these needs as the characteristics of offenders and their situations that, if intervention and change occur, are associated with reduced rates of reoffending (also see Ward and Stewart 2003). Needs are either ‘static’ and cannot be changed, such as an abusive childhood, or ‘dynamic’, which pertains to elements of the person’s current situation, such as their employment status (Hollin and Palmer 2010). Addressing criminogenic needs is central to addressing reoffending, which in turn contributes to reduced social exclusion. Hannah-Moffat (2005: 42) argues, “techniques like cognitive therapy or other programs are vehicles through which offenders can learn how to manage their criminogenic needs and reduce their risk of recidivism by acquiring the requisite skills, abilities, and attitudes needed to lead a pro-social life”.

However, as Hannah-Moffat (2005) also argues, an emphasis on prison management of criminogenic needs is potentially disadvantageous to women, in that needs associated with children, abuse and trauma have undergone a definitional transformation so that they too are now considered to be criminogenic needs (as opposed to non-criminogenic needs), which only attract meaningful therapeutic interventions if they can be statistically linked to reduced reoffending through participation in prison programs. To bracket these needs with others such as employment and education is to reduce histories of trauma to a series of statistics that fail to convey the impact of trauma on offending. Additionally, Ward and Stewart (2003) maintain that characteristics such as self-esteem, while not regarded as a criminogenic need in male offending populations, is relevant to women in prison, especially those with histories of abuse,

and that ameliorating low self-esteem should be included by prison practitioners as an appropriate criminogenic target (also see Byrne and Howells 2002).

Nevertheless, this is problematic because as previous chapters highlighted, while the criminogenic needs of the study's participants reflect those of the broader women's prison population, the presence of a cognitive disability has significant implications. Limited adaptive skills that sit alongside mental health and substance misuse disorders increase the women's vulnerability to a range of circumstances, not least of which is susceptibility to criminal offending. Basing criminogenic interventions on 'what works' for male offenders with cognitive disabilities, even with some form of adaptation, is to ignore crucial differences, thereby promoting what Baldry (2010: 254) terms "gendered penalty" as discussed in Chapters 2 and 5. The women in this study entered prison having experienced historic and ongoing trauma, with very low levels of education, minimal to no employment experience, criminogenic families and peers, intergenerational disadvantage and disrupted Indigenous communities.

In their discussion of Indigenous women who are incarcerated, Shepherd et al. (2016) highlight the inability of Australian prisons to address their key criminogenic needs: substance misuse, family violence, persistent psychological distress and issues of anger management. Evidence of this was brought to light throughout the present study, with Indigenous women such as Sandra, Belinda and Theresa experiencing numerous custodial episodes related to the same recurring patterns of drug-related offending, including multiple citations for violent behaviour against family members, police and people they were attempting to steal from. However, the three women also shared histories of abuse beginning in childhood, with criminogenic family and peer associations that fostered their use of substances and stifled opportunities for education and employment. If the criminogenic needs of both Indigenous and non-Indigenous women are to be addressed, it must happen in the context of past circumstances and not solely as response to acts of criminality that are symptomatic of far broader issues.

6.2.6 Current prison responses to criminogenic needs

Chapter 5 described the carceral status of a number of the women in this study, with remand and "serial institutionalisation" (Baldry 2010: 254) via short custodial episodes featuring prominently. This is problematic in terms of addressing criminogenic needs, which normally requires the person to have a sentence of six months or more. A psychologist from MHWP identified an issue that she believed had a negative impact on addressing criminogenic needs. In speaking about Bronwyn's offending, she said that it always occurred after binge drinking, but as Chapter 5 highlighted, the drinking itself did not start until after Bronwyn had been raped

at age 17. Sending Bronwyn to prison and placing her in maximum security did not address a criminogenic need related to past trauma, evidenced by Bronwyn's frequent custodial episodes:

> Her core issue is related to alcohol use. Almost all of her offending is related to alcohol use. I would like to think that we could address alcohol use in the community. It doesn't seem right that someone with an intellectual disability has primary issues in binge drinking, ends up in prison over 20 times (Psychologist 2 MHWP).

None of the participating prisons had programs that had been adapted for women with cognitive disabilities. As Rowe et al. (2020) highlight, even if prisoners with cognitive disability can access a criminogenic needs program, the content may lack meaning if it is delivered with no modifications that cater to impaired cognitive function. Chapter 5 drew attention to Belinda who participated in a substance abuse program on more than one occasion, but the prison TWCC psychologist said that the nature of the content and the way the program operated, by requiring verbal and written responses, was difficult for Belinda, ultimately holding little meaning for her. This was evidenced by the fact that each time she exited prison, she returned quite soon after with the same drug and alcohol issues as before. Mary also completed a high-intensity substance misuse program on more than one occasion, but its content did not have the desired outcome of initiating behavioural change, with the result that like Belinda, Mary spent very little time out of prison, unable to stay drug free.

Courses addressing the women's low literacy and numeracy levels demonstrated slightly better results, with women such as Mary, who left school at age 12 to give birth, learning to read and write, and Kelsey, who did not attend school past the age of six, also developing numeracy and literacy skills. Study participants who had a job in prison, such as Belinda and Melanie, believed that the skills learned in prison would enable them to get a job in the community. However, as practitioners from TWCC noted, it was not an absence of skills that curbed employment opportunities, but the inability to remain substance free.

The most significant problem when it came to criminogenic needs in each of the participating prisons was their limited capacity to address the most pressing need of all, trauma. Trauma was at the heart of other core needs such as unstable living arrangements and homelessness, domestic violence, antisocial and criminogenic peers, substance use, mental illness and criminality. Completing a course, regardless of its capacity to target 'criminogenic needs', was unlikely to generate a positive outcome if the deep-seated trauma carried by the women in this study was not first addressed. Practitioners from all participating prisons acknowledged this, but said that meeting these needs in the prison setting was unfeasible.

6.2.7 Need: Adaptive (life) skills

All prison practitioners emphasised the importance of adaptive (or 'life') skills as a key need for the women in this study. Chapter 5 identified these skills as conceptual (literacy, numeracy, money, time and communication), social (getting on with others, recognising manipulation and coercion) and practical (food preparation, personal hygiene and ability to commute safely). Psychologists such as Birgden (2016) advocate strongly for identifying deficits in adaptive behaviour and addressing them through prison treatment programs. She recommends that "in disability terms, this would include adaptive behaviours such as communication and social skills, as well as states of anxiety, depression and low self-esteem" (2016: 51). QAI (2016: 20) highlight the need for "evidence-based programs and support to develop life skills" as a matter of priority for Corrective Services. Young et al. (2016) argue that "prisoners with intellectual disability lack basic life skills" and that "this lack is associated with their personal circumstances prior to their incarceration. Issues like neglect, poverty and marginalisation stem from unsupportive family backgrounds characterised by a lack of basic skills training". Deficiencies in programming for this critical area was a concern expressed by practitioners. As a counsellor from BWCC commented:

> There needs to more tailored programs for these women that address life skills, resilience, and vulnerability. Programs also need to target their educational needs. Most of the women dropped out of school because they hated it. It offered them nothing and nothing made sense to them. The whole thing needs to be different.

Every practitioner who participated in this study acknowledged the importance of adaptive skills in contributing to a reduction in criminogenic needs. They also highlighted that developing these skills would result in improved outcomes in the women's day-to-day functioning, especially with matters relating to fulfilling obligations (e.g., ensuring adherence to bail, parole or probation conditions) and engender motivation to tackle other aspects of their lives (e.g., employment and civic engagement). When discussing the importance of adaptive skills for women with cognitive disabilities, and the repercussions of having limited capacity in areas such as discerning appropriate/inappropriate relationships, the ALO from BWCC said:

> The crucial thing is daily living skills. It can't just be you're expected to go to your one parole appointment a week or whatever it is, and have supported housing, but without any purpose, and with antisocial associates. I think it's quite hard to expect someone to do that.

Prison psychologists in BWCC, TWCC and MHWP noted the correlation between compromised adaptive skills and vulnerability to coercion. They also highlighted that an absence of life skills substantially contributed to reoffending because of an inability to discern

safe/unsafe relationships or to manage money. Other skills like shopping for and preparing food, maintaining personal hygiene, avoiding unsafe sex, getting to appointments, managing medications and knowing how to access support were also identified by these practitioners as central to safe and integrative community living. All participating practitioners acknowledged that the prisons in which they worked did not address living skills for the women in the study. There were no programs or processes in place to develop what they regarded as essential skills for a greater level of safety in both the prison and community settings, particularly with respect to coercion and the ability to recognise and avoid potentially damaging relationships.

6.2.8 Current prison responses

Current prison responses can be summarised very briefly: this is not an area that receives attention, as the selection of practitioner reactions to questions about life skills demonstrates. Collectively, practitioners felt that unless adaptive/life skills were addressed, the impact of interventions such as substance abuse and other criminogenic programs would be minimal. Holistically supporting the women in this study was viewed as essential, and yet as a rehabilitative approach, there was little evidence of its implementation.

Building resilience, especially in terms of reducing vulnerability to predatory behaviours, was seen as crucial if there were to be meaningful changes that translated into safe lives. As the ALO from TWCC commented when speaking about Belinda, “I don’t think we’re really doing anything to help at the moment, in terms of her being able to be better skilled out there. We’re just kind of helping her manage in here”.

Practitioners recognised the links between an absence of adaptive skills and interactions with the CJS, expressing frustration that prisons did not have measures in place to build these skills. A psychologist from MHWP spoke at length about the kind of program content she believed would be of great benefit to the women with cognitive disabilities in her care. Her ideas encompassed many aspects of daily living, from practical skills to less corporeal concepts such as personal relationships:

> If there was something we could do in here [prison], like writing a shopping list, working out what you’re going to eat during the week, budgeting your money, cleaning, hygiene, activities of daily living. Then working through social stuff, scenarios like ‘you’re invited to a party and you turn up and this happens, how do you manage it?’ Just interacting politely, and how to have conversations and meet new people. Talking about how to structure a day so it’s used productively. I think all that would be brilliant (Psychologist 2 MHWP).

Acknowledgement that prison undermines resilience and self-confidence by offering nothing in the way of life skill development was echoed by several practitioners, for example:

> She's clearly not getting anything out of it, except thinking that she can't survive in the community, or successfully integrate, and thinking that she's bad, because she keeps getting in more and more trouble (Psychologist BWCC).

Psychologist 1 from MHWP summarised the situation when she spoke to the fact that ultimately, each of the women in this study will be released from prison, but they are being released with no skills to avoid or negotiate the same circumstances that contributed to their CJS involvement. She stressed that:

> It's always been one of the things that has upset me the most about working here [prison]. I really do think it's wrong that some people are here, and treated exactly the same, particularly at the women's [prison]. Not so much at the men's because it's a bigger prison. I worry about them when they actually get out of prison. It's got to happen, so…

Perversely, the prison itself provided an environment in which certain skills had to be acquired by most of the women (except for women accommodated in safe or detention units) in order to adhere to prison regulations. These skills related to routine tasks such as making a bed, cleaning the cell, contributing to the cleaning of the unit in which they were housed and being rostered on to clear dishes away. For many of the women, these were skills they had never performed prior to coming to prison. Despite their mundane nature, several women commented about the fact that they could now do those tasks. Melanie, who was accommodated in one of the several houses that formed the minimum-security area of TWCC, said:

> I'd never even made a bed in my life before I came to prison. I didn't know how to do cleaning. Now I help the girls keep this house nice. I think it looks really nice. So now I know how to do my gardening job, and I'm a pretty good cleaner too.

The ALO from TWCC said it was often easy to overlook the value in acquiring basic skills. She said that for many of the women entering prison who had experienced chaotic lives, day-to-day tasks in the prison provided the only sense of order and structure they had ever known, as well as a sense of making a positive contribution to a shared environment.

6.2.9 Need: Family/community support

Chapters 4 and 5 drew attention to the lack of support experienced by many of the women, from either their families or communities. In fact, criminogenic families directly contributed to several women's interactions with the CJS, starting at an early age. While there were a minority of exceptions, such as Renata, who had a stable and loving upbringing, most of the women had

experienced dysfunctional family life with unstable living arrangements. However, several of the women spoke about family members who offered support. Rosie talked about her grandmother as someone she relied on, especially as her 'nan' was caring for Rosie's daughter. Noelene's brother and niece, after many years of estrangement because of her drug use, reached out to her in prison, promising to visit and to help her post-prison. Deidre was excited because her sister and brother-in-law were going to help and support her when she was released on parole, which was due to take place shortly after the time of interview. Others, such as Rachel and Erica, relied on their grandparents for support. For these women, such connections were pivotal to their sense of wellbeing, with many references made to their significance during interviews.

In conducting this research, the importance of family was reinforced by the women, as well as by practitioners such as the ALO and ODM from TWCC who acknowledged that these connections played an important role in maintaining a link with 'outside' and providing hope and greater security for life beyond prison. Family connections were viewed as a critical resource for the women, particularly the study's Indigenous women. Practitioners from BWCC and TWCC identified the deleterious effects on mental health when family and community connections were severed because of incarceration, especially when separated by hundreds of kilometres. As the ALO from TWCC highlighted, "family links are crucial, and for the Indigenous prisoners the involvement of community Elders".

For the women in this study, the need for community support is also fundamental. This should be based on inter-agency cooperation (such as mental health services, housing, disability employment, substance use interventions, CPS liaison and family violence support). The ALO from TWCC spoke at length about this issue, commenting that:

> We really need stakeholder engagement—this is paramount. As it is at the moment, stakeholders like corrections, probation and parole, housing, and employment, don't have a true understanding of cognitively impaired prisoners, either Indigenous or non-Indigenous. Everything has to be resourced differently, to create a working model that caters to the specific needs of these women.

Women with cognitive disabilities are considerably more at risk of offending because they lack adequate support to live in the community (QAI 2015). Various scholars highlight the substantial benefits derived from such an approach (e.g., McCausland et al. 2013; Rees 2010; Rowe et al. 2020), which increases social capital while simultaneously decreasing marginalisation. Young et al. (2016) contend that community connection is imperative because of the entrenched social isolation that women with cognitive disabilities who experience incarceration are subjected to. As Rowe et al. (2017: 12) argue, "it is well established that a

continuing lack of appropriate service provision in the community has directly contributed to the criminalising of and disproportionate representation of people with cognitive disability in prison". Similarly, Villamanta Disability Rights Legal Service (2012) stresses that to effectively address reoffending, strong partnerships with the disability, mental health and broader health and community organisations are central to generating positive outcomes for women with cognitive disabilities.

6.2.10 Current prison responses to family and community support

Overall, the response by prisons to family and community engagement with respect to the women in this study was mediocre. The vast majority of family and community connections in the participating prisons emanated from volunteer organisations. For example, the Onesimus Foundation in Hobart enabled video visits between the women and their families and children, operating throughout Tasmania via a number of regional churches who organised and facilitated these visits. This was unique and, at the time the research was conducted, was not replicated in any of the other participating prisons. Although ALOs in the participating prisons worked hard to maintain connections between Indigenous women and their families and communities, this was an area in which they were under-resourced in terms of facilitating prison visitation involving travel and/or accommodation for visiting families. Prisons did not assume a 'hands on' role in keeping families connected. Where contact was established, this was often achieved through outside agencies such as Prison Fellowship, South Australia's Second Chances, QLD's Sisters Inside and Tasmania's Onesimus Foundation.

The nature of prison rules and regulations impeded family visitation for many of the study's women. Chapter 5 discussed several of these issues, such as a family members' lack of formal identification or their criminal record. The need to bring the required paperwork to the prison for every visit, including children's birth certificates, meant that visitors were turned away if they forgot to bring this documentation. Unfriendly custodial staff was cited by Mary as an issue impacting both the quality of visits and family members' motivation to organise a visit. Despite recognition by practitioners of the importance of these connections, the tension between prison processes and family member visitation represented a significant barrier to maintaining family links.

For the women in this study, connections with community were absent, despite various scholars (e.g., Lloyd et al. 2015) highlighting the importance of connections between prisoners and the community, particularly community services and support, prior to release. Elder visits were more common and were identified by practitioners and the women as having a positive impact.

A psychologist from BWCC expressed a view echoed by other participating practitioners when speaking about community support, which she felt was far preferable to a prison sentence:

> Most of the women with cognitive disabilities shouldn't be in prison in the first place. They should be receiving the support that is needed in a supported community environment (Psychologist BWCC).

Building and promoting community/prison partnerships that include women with cognitive disabilities is central to reducing their social exclusion upon release. Having these associations embedded in the 'fabric' of their time in prison has the potential to generate a ripple effect of benefits, particularly connections that are removed from criminogenic associations, in addition to promoting civic engagement. While each of the prisons ran community service programs (e.g., with the RSPCA or the Greyhound Adoption Program), none of the women in this study were a part of these initiatives and it was widely believed by practitioners that they would never be considered 'suitable' candidates. It is participatory opportunities like these that have the potential to engage women with cognitive disabilities in a venture that demonstrates the value of giving, an effective tool in the promotion of self-worth, however it was not a rehabilitative avenue open for study participants.

6.2.11 Need: Cultural sensitivities

A discussion of 'cultural sensitivities' arises from the comments of several of the study's Indigenous participants, such as Susan, Caroline and Rosie, who felt that there were prison staff, particularly custodial officers, who were disrespectful of their cultural heritage and discriminated against them on the basis of their Aboriginality. The first consideration when addressing 'cultural sensitivities' is the fact that incarcerated Indigenous women are not a homogenous group. As Rynne and Cassematis (2015: 97) highlight, "in all likelihood, in one institution there will be members of different moieties, clans, and skin groups. Such variation includes (but is not limited to) significant differences in language and spirituality". Second, for Indigenous women with cognitive disabilities, being incarcerated exacerbates trauma-related psychosocial disabilities (Baldry et al. 2015; Baldry and Cunneen 2014). Traditionally, prisons have adopted a one-size-fits-all approach to programming, overlooking Indigenous cultural methods that may help mitigate distress and anxiety (Shepherd et al. 2016; Shepherd and Phillips 2015). The needs of incarcerated Indigenous women are often addressed through in-prison programs designed for Indigenous men, or through mainstream programs for women, but which are not culturally specific. This is counterintuitive for imprisoned cognitively impaired Indigenous women, most of whom have been affected by prolonged family violence, including sexual abuse, and who continue to suffer the ongoing effects of colonisation

(Sherwood et al. 2015). As such, trauma-informed approaches to therapeutic and criminogenic needs programs are essential, particularly given that women such as Belinda, Sally and Rosie were descendants of the Stolen Generation. For women like Susan, Kelsey and Noelene, who were struggling with their cultural identity, the need for supplementary programs in addition to Elder visits were viewed as essential by ALOs from BWCC, TWCC and AWP. The ALO from AWP said that these programs, which foster cultural pride and a deeper understanding of heritage, should be available to all Indigenous women regardless of security rating.

The need for programs to be designed and developed by Indigenous organisations, and to be delivered in women's prisons by Indigenous personnel, has been identified by various organisations and scholars (e.g., ALRC 2018a; Callan and Gardner 2005; Miller 2007). Additionally, scholars such as Heffernan et al. (2012) emphasise the need for not only culturally sensitive programs in the prison setting, but for those programs to be available in the community post-prison. Scholars and practitioners agree that support for cognitively disabled Indigenous women must move away from a reliance on mainstream programs and embrace a more holistic approach that seeks to address not just criminogenic needs and offending behaviours, but also work towards healing the deep-seated grief experienced by the women (AHRC 2004; Calma et al. 2017; Clear Horizon 2013; Frankland et al. 2010).

6.2.12 Current prison responses to cultural sensitivities

The ALO from TWCC explained that a number of Aboriginal and Torres Strait Islander staff are employed by QLD Corrective Services in BWCC and TWCC, including ALOs who provide support with court appearances via video link; contact with families, communities and Elders; and assistance with financial matters such as reinstating Medicare and Centrelink benefits pre-release. The QLD Corrective Services Aboriginal and Torres Strait Islander Coordination Unit works with a range of agencies and community justice groups to assist Indigenous women in QLD prisons and, at the time of interview, were helping Belinda with a pre-release program. Sisters Inside, a QLD agency dedicated to the support of women offenders, is funded to provide pre- and post-release support programs to Indigenous women. Both Belinda and Sally were supported by Sisters Inside during previous custodial episodes, although they had not met with them during the time that this research was conducted. Culturally sensitive rehabilitation programs, including the Positive Futures Program (a strengths-based program addressing substance abuse and violence), are offered in QLD's women's prisons, but none of the Indigenous women in this study had participated. AWP employs an ALO and has a Visiting Elders Program, as well as the Respect Sista Girls 2 Program aimed at cultural awareness and

wellbeing. Caroline was a participant in the Visiting Elders Program. At the time of interview, MHWP did not offer any programs specifically for Indigenous women.

Despite these initiatives, ADCQ (2019) highlights the fact that incarcerated Indigenous women are more likely than non-Indigenous women to be subjected to segregation and seclusion within the prison for breaches of discipline. They are also more likely to be placed on a safety order in response to mental health disorders, including self-harm and suicidal ideation, although as Human Rights Watch (2018) highlights, this response significantly worsens Indigenous mental health. Indigenous participants in this current study drew attention to the tension between 'white fella ways' and Indigenous cultural practices. This was particularly evident in QLD, where participants such as Susan, Rosie, Belinda and Melanie felt disconnected from Country and their communities because of incarceration. Elder visits were not generally available to women in detention or safe units, which at the time of interview affected Susan, Theresa, Alice, Jennifer and Noelene. This form of exclusion was particularly detrimental for these women who were deeply affected by their isolated accommodation. The response by prisons to cultural sensitivities was modest, especially given the benefit of receiving an Elder visit that would far outweigh the (limited) inconvenience for prisons in facilitating these visits to isolated women.

6.2.13 Need: External support services

Adequately funded external support services are an essential need for all incarcerated women with cognitive disabilities. This involves a coordinated approach to obtaining the services that will best facilitate the identification and administration of assistance aimed at reducing the effects of criminogenic and psychiatric needs, and importantly, ensuring that they are not discriminated against on the basis of cognitive disability. While the point can be made that all women exiting prison could benefit from the help of external support services, there is unambiguous evidence that women with cognitive disabilities are especially disadvantaged and vulnerable, less likely to obtain employment and more likely to return to unstable living arrangements, including homelessness and domestically violent situations (AHRC 2004; Baldry 2010, 2014; McCausland et al. 2013; Rowe et al. 2017). However, as things currently stand, "the systematic provision of evidence-based, holistic and specialised support for people with cognitive disability who are in contact with the criminal justice system remain as of yet, aspirational at best" (Rowe et al. 2017: 12).

Women with cognitive disabilities who end up in prison need support packages that work holistically, and central to this are needs associated with their disabilities, which for most of the women in this study augment other disadvantages that have marked their lives. Empirical

research clearly demonstrates that the provision of funding to maintain services that are capable of delivering the supports necessary for addressing the complex needs of cognitively disabled women is critical if cycles of offending are to be reduced or eliminated (Baldry and Borzycki 2003; Clift 2014; McCausland et al. 2013; Villamanta Disability Rights Legal Service 2012). This approach is not one that funds the women directly; rather, it seeks to fund the services that will best deliver positive outcomes across a range of areas, including accommodation, life skills, substance misuse, safe relationships (particularly with respect to domestic violence), mental and physical health, community connections and civic engagement, employment, help with CPS-related matters, parenting, and reconnecting with (pro-social) family and peers. Dowse et al. (2016) point out that to have a positive impact on complex support needs, there must be a shift away from single-service systems and a move towards multi-agency engagement, requiring cooperation and coordination between service providers (also see Hallahan 2013). This is paramount for any sort of funding model and service delivery to be effective. Connections with the women need to be established via in-reach services that are available while the women are in prison and, importantly, continue once they exit. This is a challenge because, as Chapter 5 identified, all too often these women have been 'lost in the system', with responsibility for them 'hand-balled' between different agencies. Adequately funded external support services working cooperatively is a necessary step towards minimising the women's future involvement with the CJS.

6.2.14 Current prison responses

At the time this research was conducted, service provision to this group of women in all participating prisons was in a state of flux, with a lack of a coordinated approach between various government and non-government organisations. However, the most confusion in the prisons arose from the rollout of the NDIS, a multibillion-dollar Australian Government program offering eligible people a flexible, whole-of-life approach to supporting their needs and achieving their personal goals. This will be discussed more fully in Chapter 7, but it is worth noting here that the NDIS has the capacity to deliver each of the needs identified above. However, the access of the women in this study to the NDIS was ill-defined, despite evidence from New South Wales Corrective Services of the substantial benefits of creating specialist teams of support managers for offenders with cognitive disabilities (Rowe et al. 2017).

Apart from the potential for the NDIS to deliver funded services, the participating prisons had little in the way of service support for the study's women. Non-government organisations such as Tasmania's Baptcare assisted with accommodation, as in the case of Bronwyn (for more information see Bronwyn's story in Appendix 6), but women like Susan who were due for

release shortly after the time of interview received very little support over and above the prison securing two night's accommodation at a motel, bus money and an initial Centrelink payment. The potential for appropriately resourced and capable mainstream services to manage a transition such as Susan's, and to continue with ongoing support and maintenance of relationships with support providers, would improve both individual case management and outcomes for vulnerable women.

6.3 Conclusion: Do prisons meet the needs of cognitively disabled women?

When conducting this research, the input of the women and of prisoner practitioners was invaluable, providing a coalface view of the lives of a group of cognitively disabled women, both Indigenous and non-Indigenous, and those who regularly interact with them. At the start of the process, the temptation to respond to the above question by simply saying 'no they don't' before moving on was uppermost. And yet, the answer is not that simple. It is true that such a rejoinder can be justified on a number of different levels, with inadequate responses to women with cognitive disability across each of the participating prisons a primary concern. However, while proffering broad agreement with that position, it is done in the knowledge that the practitioners who participated in this study were unquestionably committed to the women, and that shortfalls in addressing identified needs had little to do with their expertise or desire for improved outcomes and more to do with substantial caseloads, lack of resources for specialist support, and institutional reluctance to spend time and money on a comparatively small prison population. Despite practitioner recognition of the dearth of appropriate interventions for cognitively disabled women, as discussed in Chapter 5, they were able to provide only minimal assistance with criminogenic needs, adaptive skills, or therapeutic interventions. Practitioners were tasked with extracting as much support as possible from an under-resourced system, and it was mostly their goodwill and resolve that propelled the delivery of services. In addressing the women's needs identified in this chapter, it was apparent that prisons have limited capacity to meet those needs in any substantive way. Obvious tensions between trauma-informed care and recovery and an emphasis on security and risk management were evident in each of the participating prisons. Prison programs and systems of care were often disjointed, operating around the demands of the prison environment. For example, lockdowns and changes to staffing rosters were disruptive and unsettling to cognitively disabled women, especially for those who were attached to, or dependent on, particular staff members who extended kindness.

Young et al. (2016: 11) state that, "there is a clear need for evidence-informed screening and identification processes for people in custody with intellectual disability". However, screening for both cognitive disability and mental illness was inconsistent across jurisdictions, with the

potential to remain unidentified. Recognition of both is important, although as practitioners remarked, even when the presence of a cognitive disability was known, there were no discrete protocols or programs in place. Significantly, when it came to the important area of mental health, approaches oriented towards recovery, which promote social inclusion through an increased confidence to participate and engage, were difficult to accomplish in the context of the prison where limiting risk was prioritised. One of the most contested protocols was (and is) the use of seclusion for cognitively disabled women with mental health disorders. For the study's women, this was traumatic and potentially harmful, running the risk of promoting long-term emotional and psychological damage. Additionally, as both psychologists from MHWP identified, prison efforts to minimise peer abuse of vulnerable cognitively disabled women occasionally resulted in the isolation of the women in segregated custody or maximum security.

As evidenced in Chapter 5, program participation among the study's participants was negligible, mostly due to low literacy levels and compromised cognition, which made understanding and responding to course content challenging. The counsellor from BWCC and the ODM from TWCC noted that relevant criminogenic programs that would potentially help the women, such as substance misuse, domestic violence and anger management, often had waiting lists. A further impediment noted by the ODM from AWP was the fact that prison program delivery was highly dependent on available funding, so if this was reduced or withdrawn, then programs were often not reinstated and, in some cases, came to an abrupt halt before they reached their conclusion. The pivotal area of life skills was not addressed in any of the participating prisons, despite all practitioners stating that this was as important for cognitively disabled women as programs targeting criminogenic needs. They maintained that if adaptive and life skills were developed, the decrease in vulnerability would potentially see a corresponding increase in protective factors and a decrease in coerced criminal behaviours.

All prisons were aware of cultural sensitivity, but several of the study's Indigenous women, such as Susan and Rosie, felt belittled by certain custodial staff. However, every participant spoke positively in terms of professional staff (psychologists, counsellors, ALOs and ODMs). Indigenous women depended on ALOs for a range of supports and valued the input of visiting Elders in helping them remain in contact with communities, families and cultural heritage. In relating this information back to the question of whether prison responds to the need for cultural sensitivity, the answer must be informed by the fact that the prison itself is a culturally insensitive institution. Prison operates on principles created and maintained by dominant (white) social groups, which manifest in ways foreign to Indigenous lives that are premised on reciprocity, an absence of individualism and 'ownership', and kin networks spanning thousands

of years. Indigenous spiritual and cultural heritage is suppressed, or worse, lost, in the context of incarceration, leading to an escalation in mental health disorders, community disintegration and increased family violence, which 'cultural sensitivity', while moving in the right direction, cannot respond to.

Based on the input and observations of prison practitioners, and supported by the wider literature, it is possible to conclude that prison has limited capacity to meet the evidence-based needs of women with cognitive disabilities. Practitioners acknowledged each and every need discussed in this chapter, but admitted that their capacity to adequately address any of them was limited by substantial caseloads and an environment in which rehabilitation and the needs of the study's women were subordinate to the prison's primary goals of containment and security.

Chapter 7: Women, Cognitive Disability and Incarceration: The Face of Social Exclusion

7.1 Introduction

This chapter consolidates the key themes, findings and contributions of this research and enhances what we know about women and cognitive disability, thus advancing the literature by providing a focused appraisal of the impact of social exclusion on cognitively disabled women prior to and during incarceration, as well as current prison responses to this prison population. From the study's findings, links between the indicators of social exclusion and those commonly associated with incarceration emerge, supporting the dissertation's principal argument that social exclusion is central to the lives of cognitively disabled, imprisoned women. Social exclusion is a conduit to incarceration, and its effects continue within the prison setting, with nominal prison capacity to respond to the needs of women with cognitive disabilities.

The work of Foucault (1977, 1980) and Goffman (1961, 1963) was instrumental in providing guiding principles for this study. Their complementary sociologies regarding the role of institutions as places of coercion (Goffman 1961) designed to transform people into what Foucault (1977) termed 'docile bodies' are continually demonstrated in women's prisons operating in the 21st century. The notion of 'exclusion' emanating from an institution designed to separate and divide those considered a threat to society is a pivotal component of Foucault's observation that not only are incarcerated people excluded from society itself, they continue to be excluded within the prison setting. This is achieved through continual surveillance and prison protocols that emphasise punishment, containment and the repression of those who are incarcerated.

Both Goffman and Foucault shared an interest in the processes of degradation and social control that accompany a person into prison. Goffman (1963) also focused on the notion of stigma and the way in which those who are stigmatised are subjected to discrimination and marginalisation, thereby reducing their life chances. In conducting this current research, the relevancy and accuracy of two preeminent 20th-century social theorists was revealed time and again, causing a cerebral shift from considering Foucault and Goffman in purely academic terms to understanding that their perspectives were, and are, a revelation, inasmuch as it was possible to see evidence of their teachings firsthand. Exclusion, stigma and reduced life chances were integral to each of the women participants, giving weight to the conclusion that in almost six decades not a great deal has changed in how we as a society treat our most vulnerable

populations. In reflecting on the women taking part in this study, the choice of 'social exclusion' as a paradigm in which to frame the women's narratives was something of an organic decision, given that it permeated most aspects of their lives. Answers to questions such as 'did social exclusion contribute to incarceration?' or 'did incarceration contribute to social exclusion' became clear as the mutually reinforcing nature of social exclusion was exposed.

The theoretical framework developed for this study, based on domains of social exclusion relevant to the state of incarceration, shaped its methodology. Domains included formal and informal networks, trust and safety, health and wellbeing, civic engagement, and agency. These domains were investigated in two contexts: outside the prison and inside the prison. Within each domain of social exclusion, indicators and themes were generated based on the extant literature and the study's thematic analysis. The use of narrative inquiry yielded rich data, used to address the three research questions, and from which evidenced-based conclusions could be drawn.

Key findings from this study contribute to advancing theoretical concepts aligned with the intersecting paradigms of social exclusion, cognitively disabled women and incarceration. They also have practical application with respect to Corrective Services, correctional policy and women's prisons in particular. The women in this study represent a rapidly growing prison population (AIHW 2018). Continuing to rely on information and evidence arising from the incarceration of males with cognitive disability is an inappropriate response on several different levels, not least of which are the elevated rates of trauma and mental illness experienced by this group of women. This dissertation frequently referenced the fact that the women who participated in the study share much in common with incarcerated women who are not cognitively disabled. However, the issue of the vulnerabilities that accompany cognitive disability were also identified as a critical point of difference between the women in this study and other incarcerated women.

From the investigation guided by the study's three research questions and the consequent conclusions reached, several common themes emerged, characterised by the relationship between social exclusion and incarcerated women with cognitive disabilities. The first relates to social exclusion and its centrality in the lives of the study's participants. Scholars of social exclusion (e.g., Bowles 2012; Buchanan 2004; LaBonte 2004; Popay et al. 2008; Saunders et al. 2008; Silver 2007, 2010; Schweiger 2013) highlight the multidimensional nature of social exclusion that includes many of the indicators arising from the findings of this research—low education, little/no engagement with employment, unstable accommodation, high prevalence of substance misuse, low levels of personal safety, absence of civic engagement, increased

incidence of mental health and pervasive stigma. Throughout the research process, the significance of these indicators was continually reinforced by way of the women's narratives, which spoke to lives dominated by trauma, discrimination and exclusion, and the weight of cognitive disability that increased their vulnerability and ensured they remained on society's fringes.

Second, indicators of social exclusion contributed directly to the women's interactions with the CJS, with evidence of targeted policing and mostly punitive responses to offending behaviour emanating from comorbidity, including cognitive disability, mental illness and substance misuse. The women's challenging behaviours were frequently treated as offending behaviours, escalating from police interventions and progressing through the CJS to incarceration. Women with histories of juvenile detention and CPS interventions were at heightened risk of entrenchment in the CJS as adults.

Third, social exclusion did not cease because the women were in prison. Evidence of exclusionary practices began with the women's entry to prison, where inconsistent identification of cognitive disability represented the commencement of marginalisation within the prison setting. This was evidenced by an absence of modified criminogenic programs designed to engage women with cognitive disabilities in meaningful participation, a lack of understanding of cognitive disability among some prison staff (e.g., custodial officers), punitive responses to challenging behaviours such as confinement in detention units, limited therapeutic interventions for psychiatric conditions, examples of cultural insensitivity, and nominal responses to the victimisation and coercion by other women to breach prison regulations.

Certain conclusions from this study resonate with other research involving prison populations (e.g., Baldry 2010, 2014, 2017, 2018; Baldry et al. 2012; Bartels and Easteal 2016, 2019; Cunneen et al. 2013; Foster and Hagan 2007; Lafferty et al. 2016; McCausland and Baldry 2017; Stathopoulos and Quadara 2014). Nonetheless, this study is unique. The narratives of its central protagonists, incarcerated women with cognitive disabilities, provide new insights that cannot be ignored, because they go beyond what is already known about social exclusion to expose the reality of 'punishing disability'. Drawing on the findings presented in Chapters 4, 5 and 6, the following discussion addresses each of the research questions.

7.2 Research Question 1: How does social exclusion contribute to the trajectory of women with cognitive disabilities into prison?

In addressing Research Question 1, the study's findings provide a window through which to view the lives of its women participants. The connections between each of the domains outside prison demonstrated the multifarious nature of social exclusion, particularly the fact that no one domain or indicator exists in isolation. The investigation of the indicators of *informal networks outside prison* (Domain 1) highlighted the impact of cumulative trauma, which could be directly linked with all other 'outside prison' domains. The study's Indigenous participants continued to feel the ongoing effects of colonisation, damaging their communities by practices of forced child removal and extreme disadvantage (Cunneen et al. 2013; McEntyre 2019; Meekosha 2011). Family dysfunction, family violence, grief and loss, and antisocial peers were directly linked with *trust and safety* (Domain 3), which highlighted the vulnerabilities associated with cognitive disability, evidenced by family and peer coercion pertaining to substance use and offending behaviours. Physical and sexual abuse commonly commencing in childhood, persisting through to adulthood and contributing to mental health and substance misuse disorders, identified during the examination of *health and wellbeing* (Domain 4).

Formal networks outside prison (Domain 2) drew attention not only to the women's lack of engagement in education and employment, but also their overrepresentation in state-run institutions such as juvenile detention and CPS. The significance of *agency* (Domain 5) was its absence, bringing to the fore the influence of cognitive disability in undermining the women's capacity to make self-determining decisions. Collectively, these domains affected *civic engagement* (Domain 6), which for most of the women was nominal. Cognitive disability, antisocial and/or challenging behaviours, substance misuse, mental illness, homelessness and criminality restricted civic engagement.

In many respects, the pre-incarceration lives of the study's participants mirrored those of the female prison population more generally. However, there was a notable departure from what are generally understood to be contributing factors to CJS involvement. In contemplating the women's stories, the reader would undoubtedly have been affected by the unkindness and cruelty sustained throughout their lives, but central to each of their narratives was the presence of cognitive disability. Their vulnerability was conspicuous, arising from cognitive function that, as prison psychologists highlighted, was, in some cases, equivalent to that of an eight-year-old child. Lack of essential life skills left them susceptible to various forms of coercion and victimisation. Many of the women came to believe the various labels assigned to them,

such as ‘retard’ or ‘stupid’ or ‘idiot’. An absence of community and institutional support, combined with punitive attitudes towards publicly displayed antisocial or challenging behaviour, paved the way for trajectories into the CJS.

Research Question 1 is important. It highlights the fact that while the experience of social exclusion may be intensely personal, exclusionary processes also operate on a higher plane. This can be seen in institutions (not just prisons, but those associated with, for example, health and education) that make assumptions about personal, cultural and social circumstances. Vinson (2009: 9) maintains that the ‘common denominator’ in experiences of social exclusion is a “lack of connectedness” that permeates the lives of those who are excluded. The women in this study represent that position. As the Mental Health Commission of NSW (2017: 6) identifies, “it is impossible to separate out the interacting factors of disability and disadvantage that commonly place an individual on the trajectory towards the criminal justice system”. With that in mind, the discussion now turns to an appraisal of the ways in which the operational processes of prisons contribute to the exclusion of cognitively disabled women.

7.3 Research Question 2: How does social exclusion manifest in prison for women with cognitive disabilities?

Despite the accepted position by criminal justice agencies that prisons, by way of deprivation of liberty, represent the ultimate punishment, the act of imprisonment is accompanied by a range of institutional processes that further punish those who are incarcerated (Turanovic and Tasca 2017). Connections between the domains relating to inside prison (Domains 7-12) highlighted the ways in which prison fosters the social exclusion of cognitively disabled women through security and regulatory protocols that make negligible allowance for compromised cognition and adaptive skills. Women and practitioner narratives exposed a lack of rehabilitative opportunities, with minimal participation in criminogenic programs or appropriate therapeutic interventions.

An exploration of *informal networks inside prison* (Domain 7) revealed the limited interaction of the women with family members and children. Domain 7’s links with *trust and safety inside prison* (Domain 9) highlighted the influence of peers inside the prison. Women who had to share a cell were occasionally bullied by their cellmate. Practitioners noted that bullying was directly related to the women’s cognitive disability and cited three main areas of concern: (1) an inability of cellmates to communicate appropriately with someone with a cognitive disability; (2) the vulnerability of women with cognitive disabilities, leaving them exposed to

bullying and threats; and (3) the women's inability to discern appropriate and inappropriate information to share. Financial coercion impacted several study participants.

Formal networks inside prison (Domain 8) also drew attention to the women's lack of inclusion in criminogenic programs. QAI (2016: 13) points out that "It is not uncommon for prisoners with intellectual impairment to find it impossible to complete mainstream programs, yet a prisoner who has not been seen to address their offending behaviour is less likely to be granted parole". None of the participating prisons had adapted their mainstream programs for the women. Chapter 6 highlighted the views of practitioners, who stressed the importance of developing the women's adaptive skills, which they believed to be as important as criminogenic programs in helping them to recognise unsafe situations and relationships.

When it came to *health and wellbeing inside prison* (Domain 10), the nature of overt exclusion within the prison was illustrated. Most of the women in this study experienced solitary confinement for reasons of mental health, self-harm and/or behaviour issues. As Chapter 5 showed, there is a substantial body of literature that identifies the use of solitary confinement as a key contributor to self-harm, suicide, anger, depression, anxiety, paranoia and psychosis (e.g., Human Rights Watch 2018; Norden 2019; Ogloff 2015). However, as noted by Human Rights Watch (2018), solitary confinement under the guise of 'safety' or even 'treatment' is also regularly used as a form of prisoner management (also see Caie 2011). Grassian (2006: 328) associates the use of solitary confinement with "severe confusional, paranoid, and hallucinatory features, and also by intense agitation and random, impulsive, often self-directed violence" (also see Shalev 2014). There were clear links with *trust and safety inside prison* (Domain 9), in which the women's perceptions of feeling safe inside prison, and maintaining trust in prison staff were undermined by the distress of solitary accommodation. Additionally, time spent in these cells undermined *agency inside prison* (Domain 11), particularly for women who were placed on drug regimes, including sedatives, where matters of consent were questionable.

Very few of the study's participants had any experience of *civic engagement inside prison* (Domain 12) despite there being, albeit limited, prospects available for participation in activities that were examples of civic engagement. Community organisations such as the RSPCA in Townsville and Brisbane and the Greyhound Adoption Program in Adelaide provided a number of incarcerated women with opportunities to participate in a way that emphasised the notion of 'giving', something that the ODMs from AWP and TWCC and the counsellor from BWCC recognised as its own form of therapy for the women involved (Bazemore and Boba 2012; Norris 2002). However, as Chapter 6 noted, it was unlikely that any of the women in this study

would be asked to volunteer for these programs, even though the considerable benefits of doing so were acknowledged by all participating practitioners (Andriotis 2011; Haski-Leventhal 2009; Wilson and Musick 1999). This was partly attributed to their cognitive disability. According to the counsellor from BWCC, the women's compromised ability in terms of decision-making (*agency*), necessary when participating in a role involving animals, was regarded as a significant risk.

Inside the prison, cognitive disability defined how 'life on the inside' unfolded. Susceptibility to coercion and bullying, challenging behaviours and compromised adaptive skills sat alongside mental health and substance misuse disorders, a combination of factors attracting institutional responses such as solitary confinement. Few opportunities for program participation and/or employment reinforced the marginalisation of this group of women within an environment representing the very definition of 'exclusion'. Cognitive disability in women's prisons is not addressed well, and responses to cognitively disabled women are often punitive, punishing their disability by punishing the ways in which it is expressed.

7.4 Research Question 3: How do prisons respond to the needs of women with cognitive disabilities?

Chapter 6 identified the key needs of the women in this study, emanating from the findings of Chapters 4 and 5. While acknowledging that there may be others that could be incorporated, the needs identified here are those that practitioners considered relevant to all women participants, apart from 'cultural sensitivities' pertinent to the study's Indigenous women. These needs were: (1) the identification of cognitive disability, (2) psychiatric wellbeing, (3) criminogenic needs, (4) adaptive skills, (5) family and community connections, (6) cultural sensitivities and (7) external support services. Prison support is limited insofar as it is directed predominantly towards addressing only criminogenic needs, with the aim of reducing reoffending by targeting issues such as addictive behaviours. However, for many of the women, criminogenic programs lack meaning because they have not been adapted to cater to those with cognitive disabilities. A reliance on literacy to participate in courses and to demonstrate responsiveness to the program content is prohibitive for the majority of the women who participated in this study because they have low literacy levels and sometimes experience difficulty expressing what they think and feel. QAI (2016) highlights the fact that program development does not have to be arduous or expensive. They support modifications to existing mainstream criminogenic and education programs to create avenues for meaningful participation.

Each of the remaining needs receive even less attention, particularly the development of adaptive skills, which for this group of women is fundamental to reducing recidivism by increasing their personal safety through decreasing vulnerability. Prisons are aware of the need for cultural sensitivity, but based on information from prison practitioners in BWCC, TWCC and AWP, this does not always mean that it happens. According to practitioners, as well as several of the study's Indigenous participants, there were custodial officers whose attitude towards Indigenous women prisoners was insensitive and discriminatory. Prison psychologists were limited in what therapeutics they were able to deliver, mostly due to substantial caseloads. Practitioners noted that organising psychiatric appointments was problematic, with too few psychiatrists engaged by corrections and too many women needing their assistance. Introducing the women to funded external support services was also inconsistent among the participating prisons, due in part to the difficulties associated with 'categorising' women with complex support needs. In addition to cognitive disability, the participating women had mental health disorders, a range of challenging behaviours and various criminogenic needs, meaning that they did not 'fit' into one or another category, such as 'mental health' or 'cognitive disability'.

Perhaps the most compelling observation was the prioritisation of security and containment over therapeutic or criminogenic interventions. Practitioners in all participating prisons identified that within the prison setting, the fact that a woman has a cognitive disability makes little or no difference to how she is managed. Rule infractions, regardless of the reasons, still incur the same penalty as any other prisoner. The women are expected to understand and adhere to prison regulations, and difficulties with comprehension are not factored in, especially by some custodial officers. Even though there is general acknowledgement by practitioners that cognitive disability directly contributes to vulnerability, this does not impact the prison emphasis on security as the priority in day-to-day operations. However, several practitioners also offered an alternative view, stating that for women with cognitive disabilities, it is the highly structured nature of the prison that provides them with a sense of safety. Once they grasped the rules and regulations, their existence often assumed a stability that contrasted with their chaotic lives outside prison.

Notwithstanding this observation, an overview of the prison's capacity to respond to the needs of cognitively disabled women indicates that currently this is not an environment that offers any substantial benefit beyond providing physical separation from abusive relationships and an opportunity for women with longer sentences to withdraw from substances. The women's needs, derived from the findings of Chapters 4 and 5 and discussed in Chapter 6, are recognised as material by prisons. However, acknowledgement of these needs does not increase the

capacity of prisons, and practitioners in particular, to address them in a meaningful way. Lack of resources, and the fact that cognitive disability is overshadowed by mental health and criminogenic needs, means that it continues to lag behind in terms of a commitment to formulating strategies within prisons to better serve the needs of this group of women.

7.5 Charting a path forward: A needs-based approach

This section is prefaced by a fundamental observation, emanating from the findings of this study, of the futility of prison as a 'solution' for cognitively disabled women who have been criminalised. This is best illustrated by the collective of figures in Appendix 5, which portray the cycles of incarceration that have done little to address the causes of the women's offending, but have done much to ensure the embedded social exclusion of women who have experienced discrimination and marginalisation for most of their lives. Prison staff believed that Jennifer, with her traumatic history of loss and chronic abuse, will die in prison. Theresa and Amelia were also expected to spend most of their lives in prison. So too Noelene; with her chronic self-harming and violence towards others, staff were resigned to her either living a long life in prison, or a short life in prison if her self-harming turned deadly. Mary, aged 44 at the time of interview, a mother at age 12, imprisoned at age 22, has spent more time in prison as an adult than she has out of it. Molly, with severe cognitive and mental disabilities, is unlikely to receive the help she needs in custody, and so will probably continue to cycle in and out of prison.

In reviewing the narratives of each of the women the overriding question becomes, 'Where do we begin?' Contextualising their situation is paramount. This includes acknowledging their lives as intrinsically ones of social exclusion magnified by incarceration. As this study highlights, the additional factor of cognitive disability contributes not only to imprisonment, but social exclusion more broadly. When reflecting on the women's needs in the framework of social exclusion domains developed for this study, the following models for social exclusion, which illustrate those links, demonstrate a way forward. By focusing on the needs identified in Chapter 6 and in the wider literature, the capacity to reduce the short- and long-term ramifications of social exclusion is substantially increased. The advantage of considering the models is the fact that, while they certainly adopt a holistic view of addressing social exclusion, they distil the approach into a series of individual areas that, in combination with one another, target the core reasons for the women's social exclusion.

Figure 8 represents a *needs-based model* of social exclusion. It portrays the multifarious links between the women's needs and the domains of social exclusion that would be targeted as a result of addressing those needs. It also illustrates a key point made throughout this dissertation,

the interrelated nature of social exclusion domains. As this model demonstrates, focusing on individual needs has implications that go beyond, for example, 'identifying cognitive disability' or 'increasing adaptive skills' to encompass the broader domains of social exclusion. Note that these needs are interrelated, and that by addressing them, *all* of the domains are targeted.

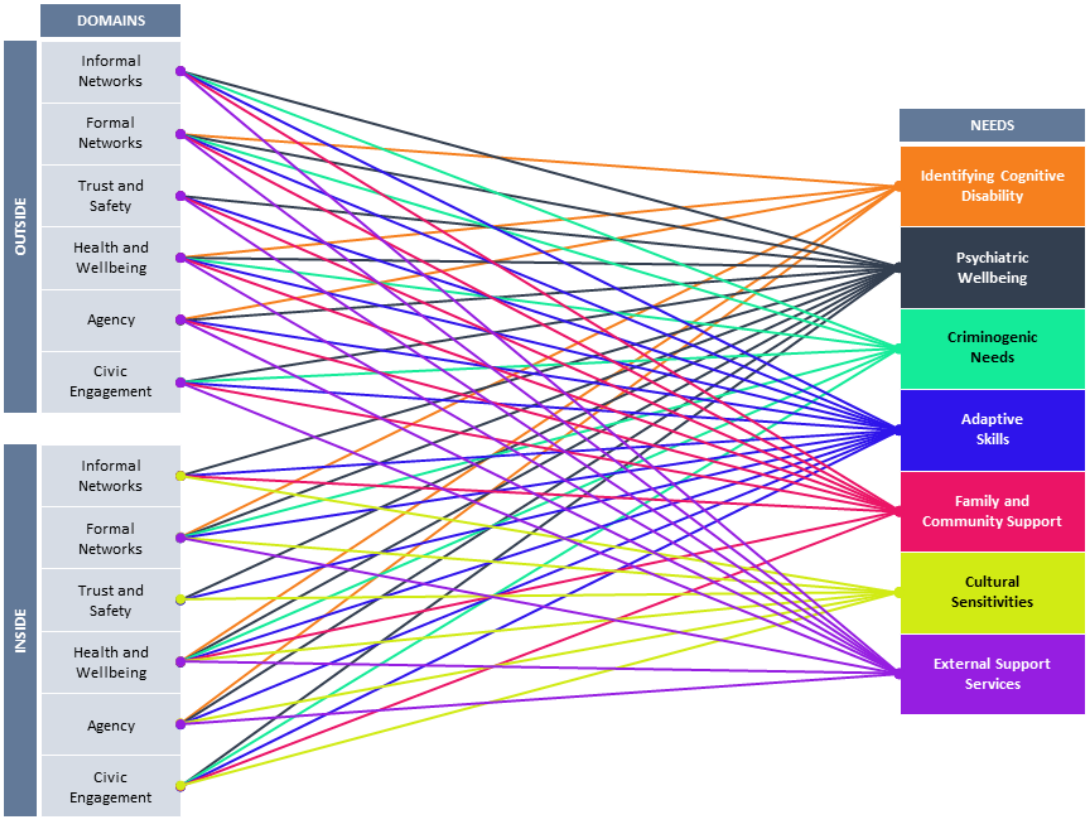


Figure 8: Needs-based model of social exclusion

The following discussion explores in greater detail the relationships between individual needs and the associated domains.

Figure 9 illustrates the way in which the 'identification of cognitive disability' has the potential to positively impact a number of social exclusion domains. Chapter 6 highlighted the arbitrary nature of determining the presence of cognitive disability on entry to prison. As a result, women with cognitive disabilities who go unrecognised are more likely to suffer marginalisation as they struggle to meet the demands of prison protocols, or to participate in programs. By initiating more comprehensive approaches to evaluating a person's cognitive ability, and how disability manifests in terms of functional capacity and vulnerability, several domains of social exclusion are targeted. For example, *formal networks outside prison*, including aspects such as appropriate housing and employment options, have clear advantages for tackling two key domains of social exclusion. First, *health and wellbeing*, focusing on mental and physical health needs, including substance misuse, is addressed in a way that is mindful of the person's

cognitive disability. This means that health information will be used in a way that is inclusive and respectful. Second, inclusion and respect are linked to *agency*, whereby the women are encouraged to participate in health-related decisions.

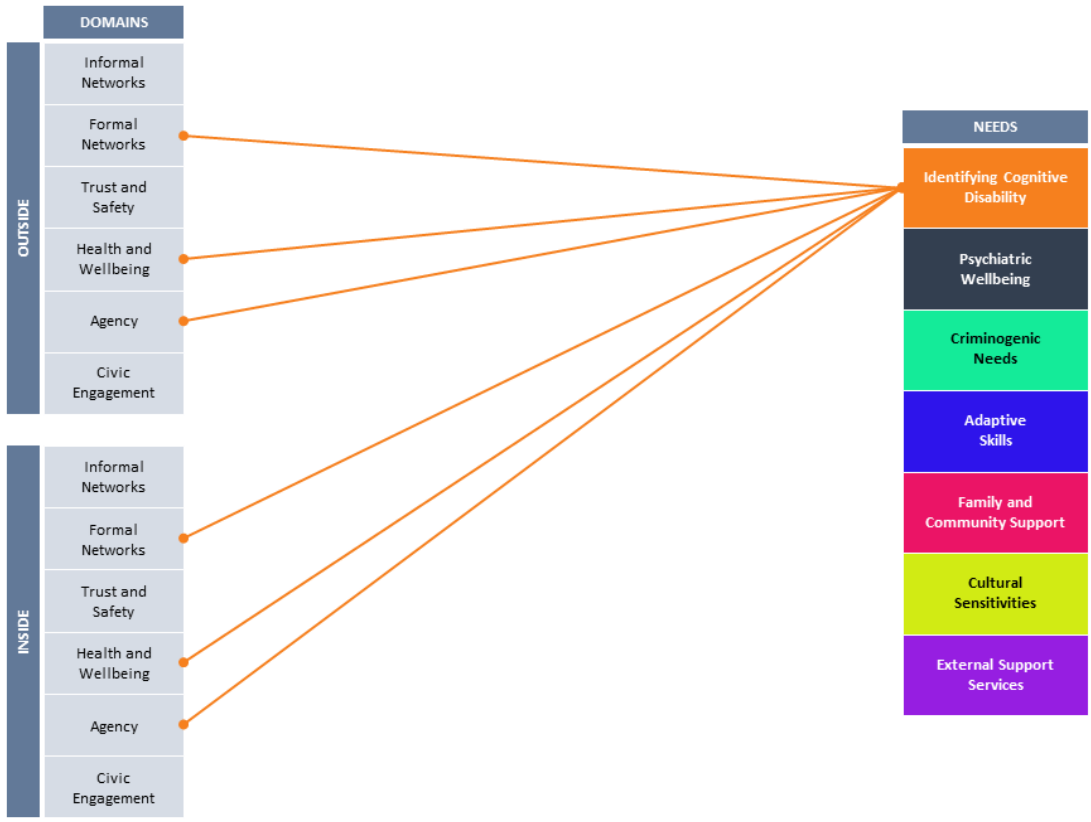


Figure 9: Identifying cognitive disability

Figure 10 illustrates the comprehensive way in which addressing 'psychiatric wellbeing' impacts every domain of social exclusion. Mental health affected each of the study's participants, and in several cases, such as Erica, Rachel and Georgina, was directly responsible for their offending behaviour. Psychiatric wellbeing represents the most complex need in this model. It is the one with the most upfront costs, and yet as a cost–benefit analysis produced by McCausland et al. (2013) demonstrates, an investment in appropriate and ongoing care will ultimately reduce costs associated with the CJS and health services. As Morgan et al. (2012: 37) point out, ""interventions specifically designed to meet the psychiatric and criminal justice needs of offenders with mental illness have shown to produce significant reductions in psychiatric and criminal recidivism"" (also see Bloom and Covington 2009). In the participating prisons, psychiatric services were limited, with long waiting lists of women referred on by psychologists for treatment. This reflects the findings of Young et al. (2019: 3) who maintain that mental health and psychiatric resourcing in Australian prisons "remains exceedingly inadequate". Continuous and coordinated care, generated via an integrated service approach emanating from health, forensic services, and CJS communication and cooperation,

provides a range of benefits, in particular, the positive impact of improved mental health of the women on quality of life, especially in terms of addressing marginalisation and stigmatisation because of behaviours associated with mental illness and psychiatric disorders.

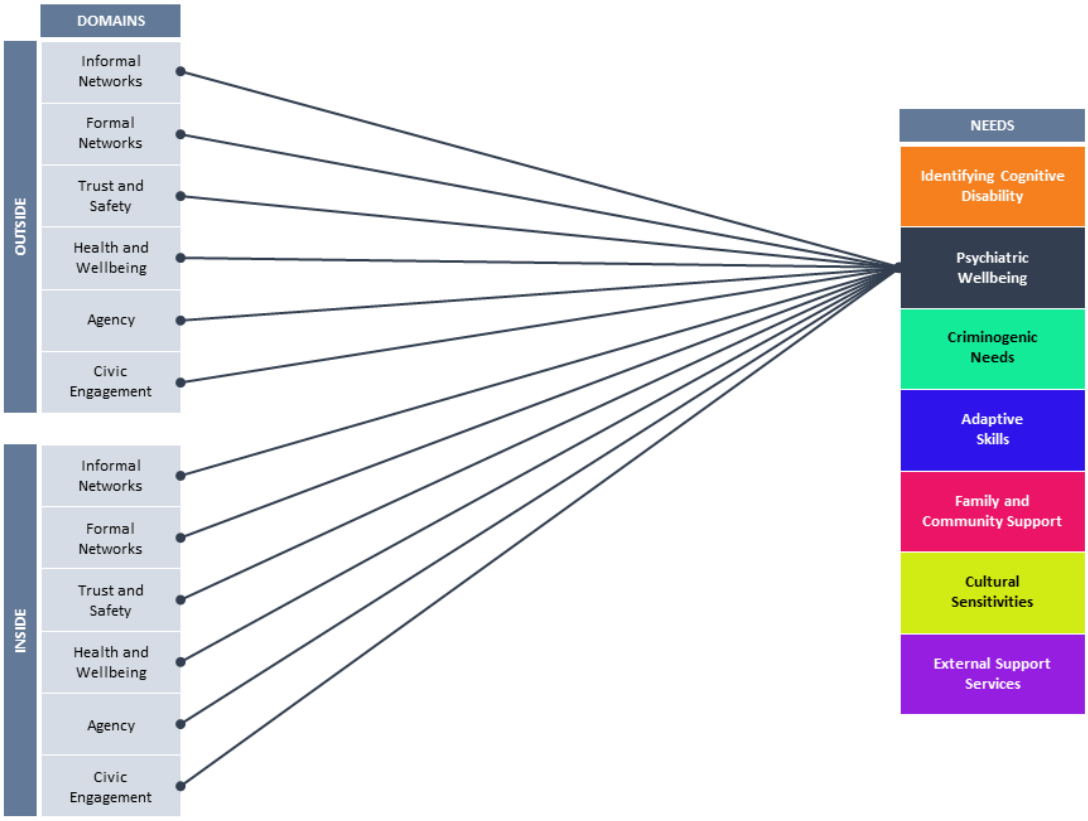


Figure 10: Psychiatric wellbeing

Figure 11 shows the links between 'criminogenic needs' and the domains of social exclusion that would be targeted. As with psychiatric wellbeing, criminogenic needs are complex, and for the women in this study, are less amenable to single program interventions. The "direct cause" model (Skeem et al. 2014: 212) that associates offending behaviour with a particular criminogenic need has only limited application to this prison population. Programs for anger management, problem solving or impulse control, while useful, should ideally be part of a broader approach that links criminogenic needs with cognitive disability, mental health and trauma, recognising the complexity of intersecting factors. The value of evidenced-based alternative approaches to criminogenic needs has immense benefit in terms of reducing social exclusion. Modifications to programs such as the use of pictures/illustrations, rather than text and written responses, would enable greater participation and more positive outcomes through increased engagement and understanding of program content.

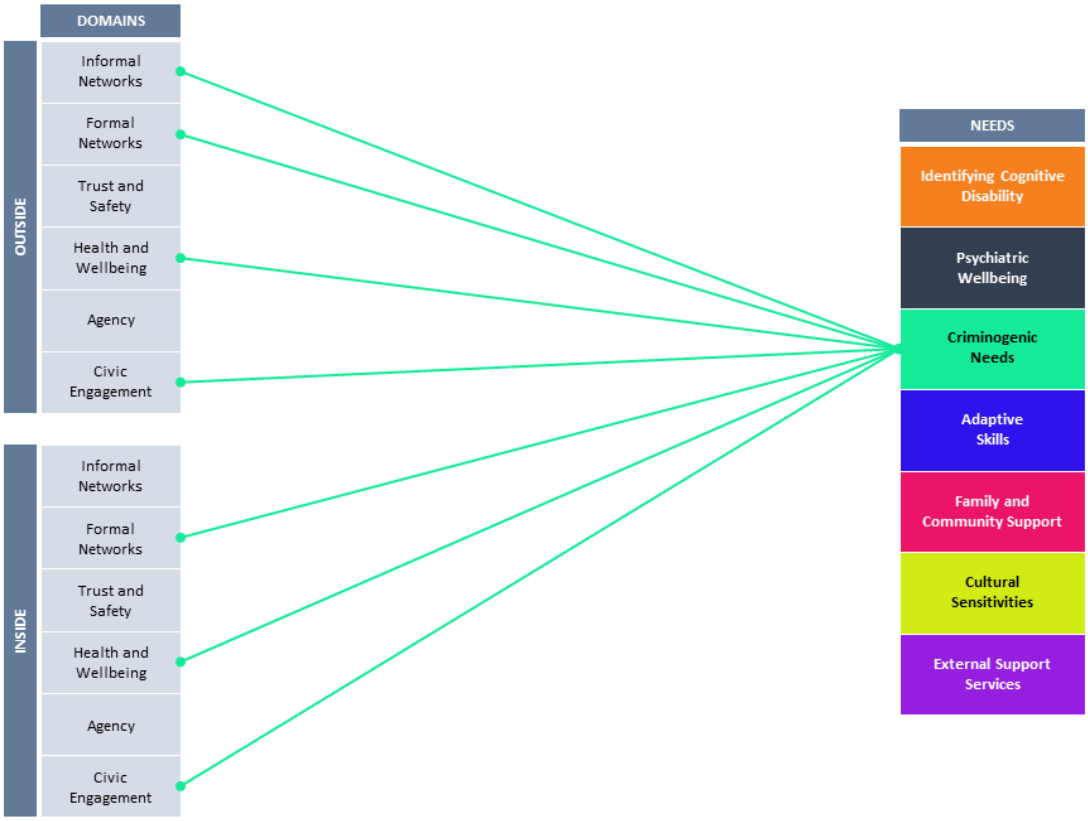


Figure 11: Criminogenic needs

Figure 12, much like Figure 10 (psychiatric wellbeing), indicates the benefits of addressing the area of 'adaptive skills', which has application to every single one of the social exclusion domains. In Chapter 6, participating prison practitioners drew attention to the critical nature of increasing these skills. First and foremost, the area of *trust and safety* would be substantially improved by generating a skillset that reduces vulnerability and increases awareness of safe/unsafe relationships and situations. This applies especially to *informal networks*, such as criminogenic family and/or peers. Engagement with *formal networks* (education, training and employment) would be enhanced by, for example, individual and group-based exercises designed to improve positive peer interactions and socialisation, or to develop work readiness. Significantly, the development of 'adaptive skills' touches the domain of *civic engagement*, central to social inclusion. Chapters 4 and 5 drew attention to the dearth of civic/community participation experienced by the women in this study, but this can be significantly improved as a result of skills that, for example, replace antisocial behaviour with responses to others that are non-threatening.

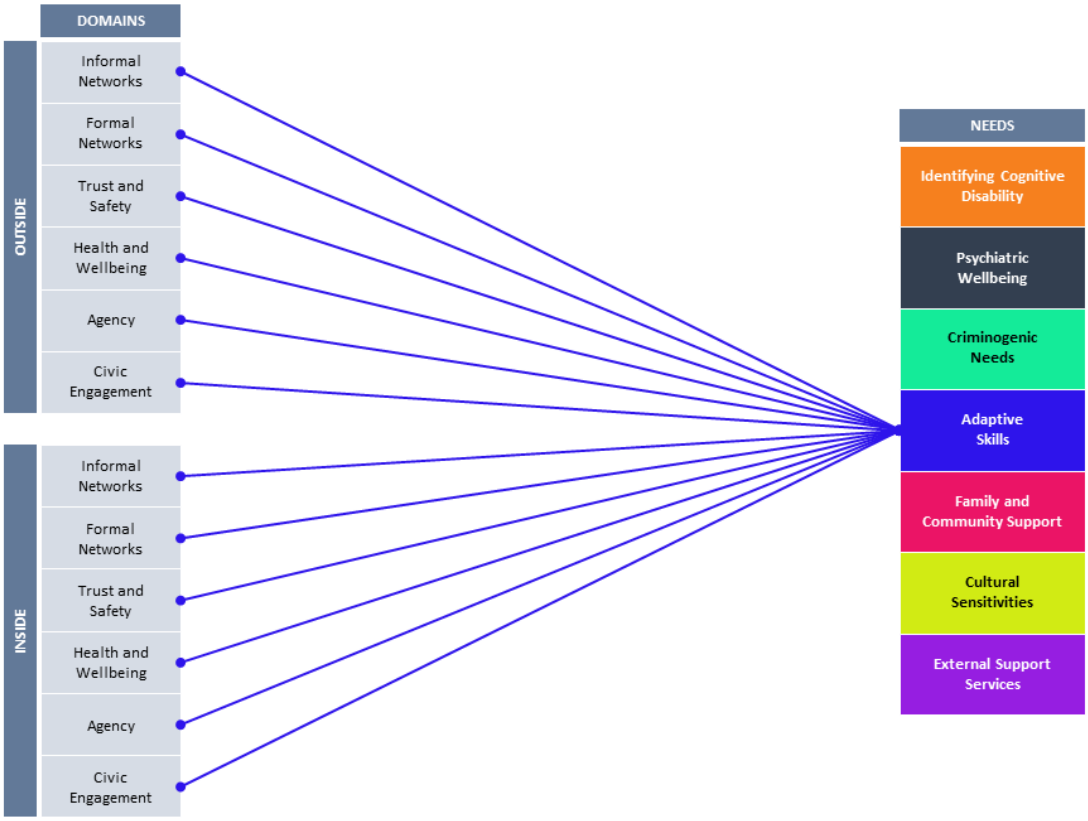


Figure 12: Adaptive skills

Figure 13 demonstrates the connections between the promotion of 'family and community support' and the domains of social exclusion that would be positively impacted. For example, for the women in this study, *agency* and *civic engagement* are often overlooked as crucial to *health and wellbeing*, *trust and safety* and reduced interactions with *formal networks* such as the CJS. Within the prison setting, opportunities for civic engagement through involvement in, for example, volunteering activities, directly affects health and wellbeing, particularly mental health, as well as creating more positive relationships with other women and prison staff. The benefits of non-criminogenic family associations (*informal networks*) have implications with respect to immediate and ongoing support inside and post-prison. Over and above improved mental health as a result of 'outside' connections, the ability to plan life post-prison, such as accommodation, family reunification, job opportunities, working towards regaining custody of children and engaging in recreational activities, bring together notions of family and community working together to provide support and practical long-term benefits that reduce recidivism and promote social inclusion.

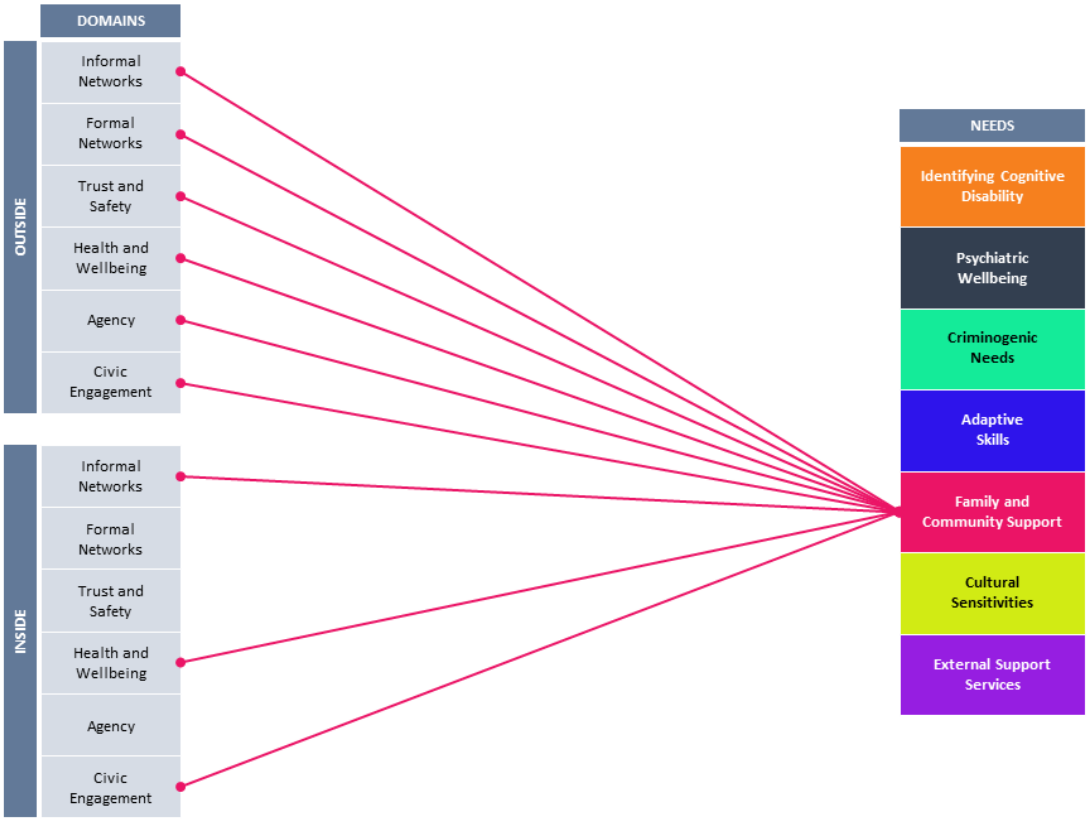


Figure 13: Family and community support

Figure 14 highlights the way in which cultural sensitivities within the prison influences every in-prison domain of social exclusion. Cultural awareness is an important aspect of prison staff training. However, as evidenced by several of the study's Indigenous women (e.g., Susan and Theresa) and in the wider literature (e.g., ALRC 2018a; Cunneen et al. 2013; McCausland et al. 2017; McEntyre 2019; Rynne and Cassematis 2015), undergoing cultural training does not always translate into practices that demonstrate cultural awareness and sensitivity, with disparate understanding of First Peoples' social and emotional wellbeing in the context of colonisation. In the absence of cultural awareness that acknowledges the trauma of Indigenous women's incarceration, exclusion within the prison will continue to engender increased psychiatric disorders (*health and wellbeing*) and further erode *trust and safety*. *Informal networks*, particularly links to community and kin, are destabilised by factors such as the women's incarceration in prisons long distances from communities, or the inability of family to visit because of an absence of formal identification. A deterioration in mental health, accompanied by behaviours that attract prison sanctions, increases interactions with the *formal networks* of the prison, mainly through confinement in detention units.

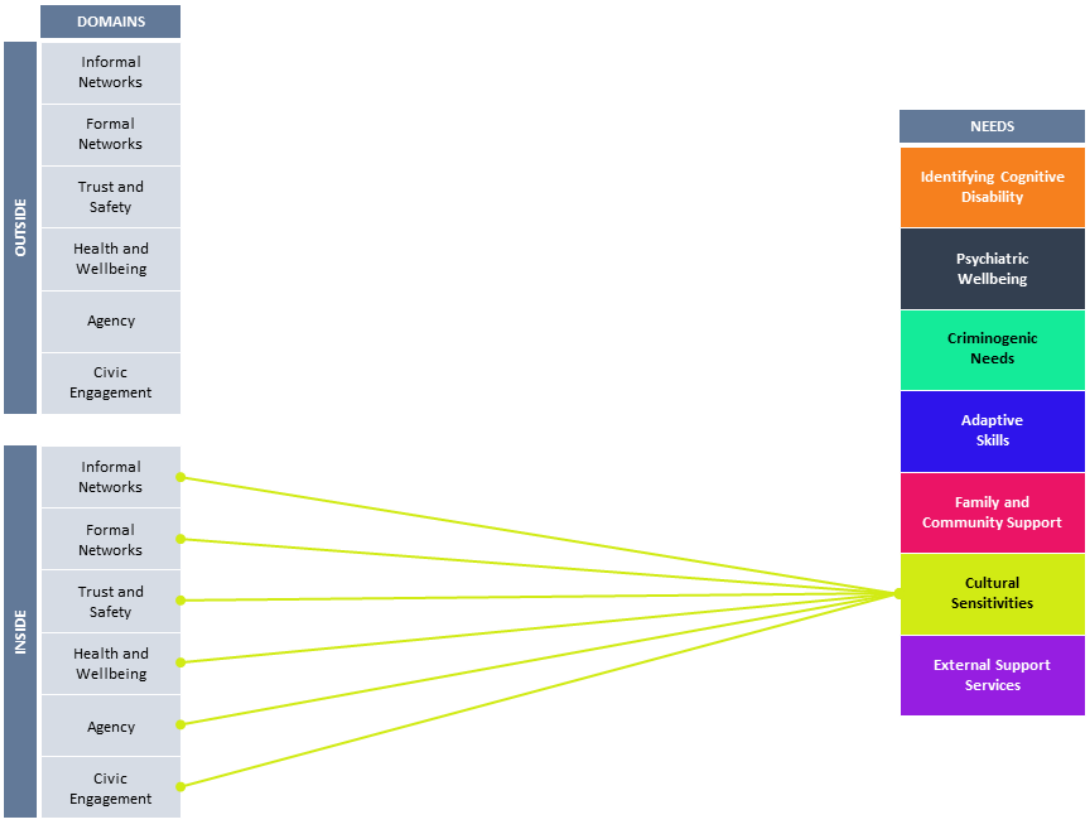


Figure 14: Cultural sensitivities

Figure 15 demonstrates the advantages of providing 'external support services', producing a flow-on effect that positively impacts social exclusion domains. For example, the ability to deliver substantive mental health interventions would have a direct bearing on *health and wellbeing*; engagement with *formal networks* such as education, training and employment; and a reduction in CJS involvement. Importantly, it would generate an increase in the women's ability for *civic engagement* and *agency*, particularly making safe choices and decisions. Services that can assist the prison to deliver support with adaptive skills would see a range of benefits, especially a reduction in vulnerability.

In Australia, the NDIS is multibillion-dollar federal government initiative with the key objective of ensuring that people with disabilities are not disadvantaged in terms of life chances by providing them with the means of achieving their goals. The NDIS funds a range of support services through individually tailored plans set up to identify a person's needs and goals. Support services include those that assist with, for example, housing options, employment, education and training, recreation, mobility and mental health, including assessment and treatment options. At the time this research was conducted, the role of the NDIS in terms of cognitively disabled women in prison was unclear, with several prison psychologists uncertain as to whether support services would be available to those in prison. There was a general

understanding that the NDIS would be available to the women several weeks prior to release, although this necessitated the appointment of a plan manager able to commit to overseeing the allocation of services. This was a significant hurdle for most of the women in this study, as they did not have appropriate support people 'on the outside'. Despite considerable caseloads, prison practitioners were attempting to navigate their way through the complexities of the NDIS to establish links between NDIS area coordinators, the prison and the women.

The NDIS represents a unique opportunity to address each of the women's needs, and in doing so, substantially mitigate their long-term social exclusion. This scheme has the capacity to target every single need, both in and out of prison. For the women in this study, and the wider prison population with disabilities, the NDIS can deliver services that are appropriate for the individual, but the key aspect is the longevity of service delivery. It is not a piecemeal, uncoordinated approach that ceases when funding and other resources dissipate. It is long term and represents an exciting prospect—*if* the CJS, and prisons particularly, can negotiate and agree on (1) ensuring the NDIS is available to the women *while they are in prison* and (2) ensuring that support for the women, via services that target their needs, is continued post-prison. Demonstrating to the NDIS the benefits of funded services for incarcerated women is critical in establishing and maintaining a relationship between the CJS and the NDIS.

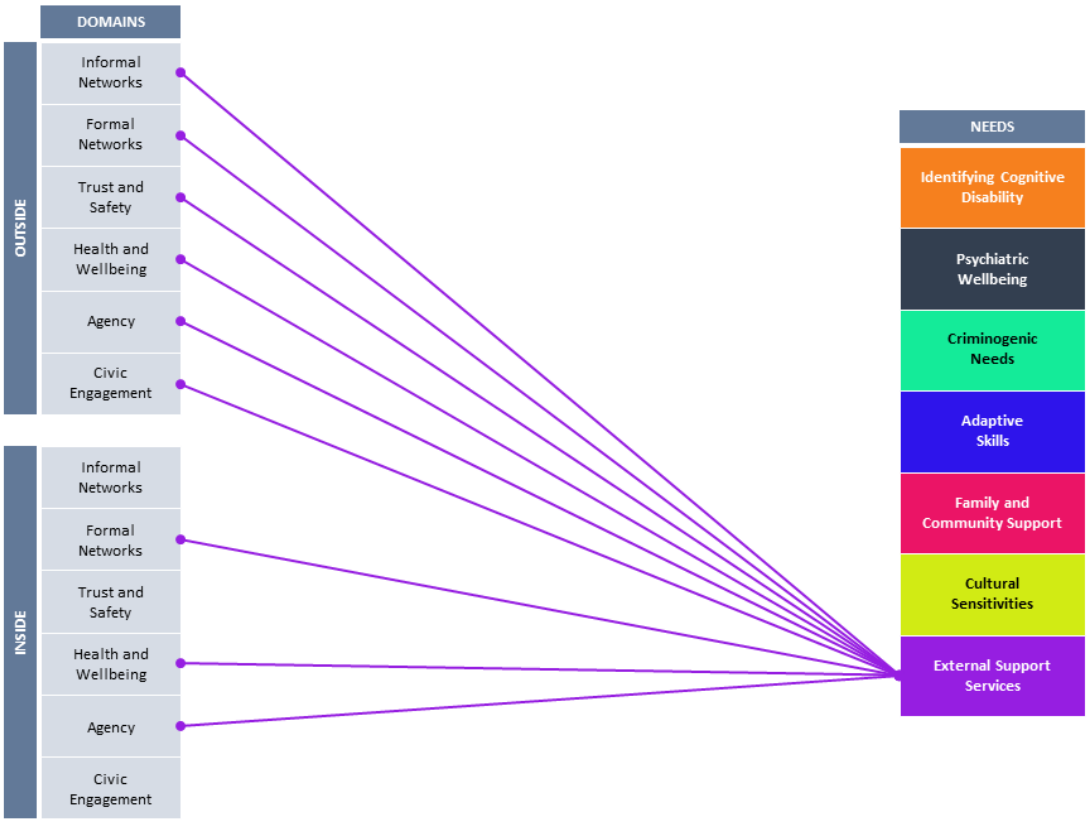


Figure 15: External support services

7.6 The implications of charting a path forward

An overriding impression when reviewing the literature associated with social exclusion, incarceration and prisoners with cognitive disabilities is the constant, and understandable, use of phraseology such as 'We must…', 'We need to…', 'We should be…' and 'It is imperative that we…'. This emanates from a position of concern: recognising the gravity of a problem and offering possible solutions to address it. However, the question arises as to *who* exactly is the 'we' and *how* exactly are these ideas going to be operationalised? How do 'we' reinvent a society underpinned by neoliberal policies and 'make' its members take up the mantra of 'inclusion', 'respect', 'dissemination of wealth', 'fairness and equality'? Silver (2010: 208), in commenting on social inclusion discourse that has as its catchphrase making people 'feel valued', thereby respecting their dignity (also see Schweiger 2013), asks the philosophical question "Can we really legislate respect?" Casting 'respect' in the light of refined manners, a good education and an equally stellar upbringing is to consign it, again, to those who meet the criteria for social inclusion. However, as Silver (2010) also maintains, exclusionary boundaries are socially constructed and can therefore be deconstructed. The challenge remains, 'how?' Reflecting once more on Goffman's (1963: 2) words, in which he states that "society establishes the means of categorising persons and the complement of attributes felt to be ordinary and natural for members of each of these categories", makes assumptions about "what the individual ought to be". This can be seen in the way that the women in this study are continually judged and evaluated based on identities shaped by exclusion.

In the lives of incarcerated women with cognitive disability, the complexity of their circumstances tended to coalesce around several life conditions that cannot be ignored. In addition to the needs identified and discussed by the above models, these are situational factors that must also be addressed head on, which can be achieved via the needs-based approach detailed in this chapter. There are many more needs that could be added to this list. However, in listening to the women's stories, the following life circumstances left an indelible impression of their contribution to the social exclusion of a vulnerable group of women.

7.6.1 Situational factor: "Because my dad done some stuff to me" (Erica): The impact of child abuse

Throughout this study, it was difficult not to be emotionally impacted by stories filled with despair. There were many examples of trauma, but the circumstances that aroused the most intense feelings of antipathy and sorrow evolved from the women's childhood experiences of sexual abuse. There were a range of situations in which this happened - fathers and/or family

members, family friends and within the realm of CPS in foster homes. In the latter context, it was the dispensable nature of children, evidenced by the lack of action taken against foster parents accused by the children of abuse, with children repeatedly moved because of their 'bad behaviour' rather than because of the actions of foster carers. Behaviours arising in response to sexual victimisation were met with punishments such as, in Georgina's case, being locked in a room, or reports to CPS requesting the removal of the child, as with Noelene.

Several of the women suffered sexual abuse as children, committed by their own fathers, family members, or family friends. Three issues, among others, were apparent. First, this abuse was normalised, in that as children, the women who were victimised believed that this was not unusual or wrong. Second, women like Jennifer and Georgina who confided in their mothers were disbelieved and repeatedly punished for telling lies. Third, the presence of a cognitive disability undermined their credibility, so they were perceived as making up stories. Prison psychologists considered childhood sexual abuse a direct contributor to early and ongoing substance misuse and mental health disorders. It is not realistic to expect that the CJS can or will address the ramifications of abuse beginning in childhood, and yet what happened *then* substantially impacts what happens *now*. Again, the irony of a situation in which going to prison provided the women with some level of psychological support, and even an acknowledgement of what happened to them, is not lost on those who advocate for alternatives to incarceration. As McKibbin and Humphreys (2020) argue, child sexual abuse is a multifaceted issue that generates emotional and defensive responses, particularly in terms of media coverage and reactive legislation. This is a valid observation, but with the exception of Kelsey, whose father is now serving a 25-year sentence for murdering the perpetrator of Kelsey's abuse, the other women have never received any support or validation prior to entering prison. By the time they were incarcerated, the effects of abuse had already caused a level of damage that was, according to prison psychologists, mostly irreparable.

Kosher and Ben-Arieh (2020: 6) point out that this is a serious public health issue and that the protection of children from violence and the promotion of their wellbeing are "major priorities in every society" (also see Lonne et al. 2019). In principle this is true, but in considering what happened to several of the women during childhood, it is difficult to imagine that "every society" is as fully committed to addressing child sexual abuse as the authors would have us believe. In looking at the *how* and the *why* of social exclusion of the women, the snowball effect of unacknowledged childhood abuse, increasing in momentum as time passed, is a reasonable place to begin. The women who were victimised revealed a sense of shame. Telling them they had nothing to be ashamed of achieved very little, and it was clear their self-worth continued to

be measured in terms of historic acts. How they saw themselves is how they perceived others as viewing them, and as prison practitioners pointed out, a small infusion of therapeutics delivered in the prison setting was unlikely to have any substantial long-term impact on redefining a sense of self.

Links between the needs-based model (Figure 8) and these experiences reinforce the centrality of several key needs, the first of which relates to *psychiatric wellbeing*. The women entered prison with histories of trauma that were augmented by incarceration. The provision of psychiatric interventions aimed at addressing past abuse is critical. It is these histories that have shaped and defined the lives of the women, including their responses to abuse suffered. Second, support to address *criminogenic needs* is critical. The vast majority of women participants had substance misuse disorders. For the most part, this was directly linked to histories of trauma. A coordinated and sustained approach to therapeutic interventions that includes a response to criminogenic needs such as addiction represents an opportunity to address the multilayered needs of these women, including dealing with anger, impulse control and avoiding antisocial peers and/or family members. Third, the development of *adaptive skills* is crucial in keeping away from/not returning to situations of abuse. These skills are essentially a toolkit to increase safety, decrease vulnerability and susceptibility to coercion, and importantly, recognise the signals of potentially unsafe situations and people.

However, there is another position that should not be overlooked, one premised on the notion of *resilience*. Wigham and Emerson (2015: 93) present a compelling argument when they say that, "it is important to avoid a disempowering perspective that paternalistically frames this population group as past or future trauma victims or to over-pathologise life experience and suggest that people with intellectual disability are not resilient" (also see Goodley 2005; McRitchie et al. 2014).

The narratives of the women in this study demonstrated their resilience, while simultaneously highlighting their vulnerability. Their pasts cannot be altered, but their futures can. The needs-based model (Figure 8) presents a way forward by demonstrating that in addressing these needs, the women's futures are less likely to involve constant CJS interactions, more likely to be socially inclusive and above all, acts of abuse will not be repeated.

7.6.2 Situational factor: "When you're on the drugs, you don't give a shit" (Alice): The impact of substance misuse

The impact of substance misuse on the women's lives formed a significant component of their narratives. Buchanan's (2004) theoretical perspective, linking substance use with social

exclusion, filtered through most stories. The notable aspect is the fact that substance addiction continues to be a CJS concern, rather than a health matter. It is not thought to be, as Buchanan proposes, a social issue. Substance misuse is incontrovertibly embedded in our CJS. Therefore, this situation continues to inform public attitudes about not only substance use and addiction, but also related problems of poverty, homelessness and how government welfare is dispensed. As noted in Chapter 2, in general, society views substance users as criminals who have brought this situation upon themselves and are to be denounced as having neither the aspiration nor the resolve to stop. The idea that 'users' exercise choice, and therefore get what they deserve, is an influential argument supported by populist 'tough on crime' agendas that encourage the process of 'othering'.

However, the status of 'deviant' does not help women in need. Entrenched stigma is underpinned by policies and political decisions made in the name of public order and punishment, rather than on the basis of scientific evidence demonstrating that addiction needs to be addressed medically. Additionally, there is abundant social science research highlighting the social, structural and cultural circumstances affecting many substance users, and certainly the women in this study. A report from the United Nations Commission on Narcotic Drugs (2014, CND: Resolution 57/4) states that:

> Substance use disorders can result in chronic, relapsing conditions requiring, like other health conditions, treatment based on scientific evidence, support for those affected and, where indicated, governmental and community initiatives to promote recovery and facilitate reintegration.

The ineffectiveness of the CJS as a manager of addiction was evident in the case of study participants who were repeatedly arrested and convicted for drug-related offences. In circumstances where the women were serving a longer sentence, they were able to stop using. However, being released without appropriate supports in place often resulted in a relapse. Criminalising the women only intensifies the problem. However, shifting the management of substance use from the legal sphere to the health domain would redirect the focus to 'people' rather than 'offenders', thereby emphasising 'humanity' not 'criminality' (Buchanan 2004; Marmot et al. 2008).

This is a position adopted by a range of scholars and organisations, including the WHO (Volkow et al. 2017; WHO 2014), who argue that the relapsing nature of addiction is preventable and treatable and, as Buchanan (2004) maintains, is not a moral deficit or an act of criminality. One of the major challenges to addressing substance use disorders is the elimination of stigma surrounding those who are affected. As noted in Chapter 2, Room (2009) and

Heijnders and Van Der Meij (2006) contend that people affected by substances are one of the most highly stigmatised groups. The women in this study also have mental illness and challenging behaviours, which contribute further to their marginalisation.

The connection with the needs-based model (Figure 8) is clear. In addressing substance abuse, there is a positive impact on *health and wellbeing*, particularly given that substance abuse and mental health are intertwined. There are obvious connections to criminogenic needs. As noted throughout this dissertation, substance misuse was central to much of the women's offending, and by addressing it via sustained and consistent interventions that are continued post-prison, rates of reoffending decrease and physical and mental health improve. Likewise, *civic engagement* is positively impacted. Several prison practitioners identified that substance misuse was often a catalyst for antisocial and challenging behaviours, resulting in social distancing and marginalisation by members of the community. Addressing addiction opens up possibilities for pro-social community engagement, thereby improving mental health and reducing criminality.

7.6.3 Situational factor: "It's not fair! I don't know what I'm doing here" (Molly): The impact of insensitive CJS processes

In speaking with the women who participated in the study, the constant theme of confusion emerged. This arose predominantly because of the processes leading to their incarceration. The Australian legal system privileges the written and spoken word. It is multifaceted, and as many lawyers will attest, difficult enough to navigate for those with a sound knowledge of legal complexities, let alone those without. Forms that require a 'brief explanation' of a person's legal problem, for example, are confronting for those with cognitive disabilities, low literacy levels, mental health disorders and cultural backgrounds outside the dominant social group. This problem has been recognised by disability advocates who acknowledge that court processes are not only challenging for people with cognitive disabilities, but also exacerbate pre-existing disadvantage and social exclusion (French 2007). Several of the study's participants had only a vague idea of the charges against them and their legal implications.

The duality that sometimes occurs between several study participants' position as both victim and offender is concerning. Police responses that routinely apprehend women accused of assaulting their partners fail to recognise the women's histories and the circumstances culminating in a violent response. Past and ongoing trauma, contributing to defensive responses aimed at protecting themselves and/or their children, continue to witness the criminalisation of women such as Melanie. When speaking with her, she was very open in acknowledging what she did. Nevertheless, her crimes need to be viewed within the context of other aspects of her

life, such as little money, poor education, unemployment, community dislocation, substance abuse and mental health issues, all of which affected her capacity to fully understand CJS processes, especially those pertaining to police instructions/cautions, and court proceedings.

Each of the women who had to make a court appearance via video link experienced high levels of anxiety and stress. Chapter 5 highlighted Sally's confusion over her impending video link court date, about which the ALO was unable to provide reassurance. Sally just wanted to "go back to my community" and to "tell the judge that I'm going to be good now" which she believed would end her incarceration. Molly was also highly agitated by her forthcoming video link court appearance. If access to justice is, as various authors and agencies recognise (e.g., ALRC 2013; Grunseit et al. 2008; McSherry et al. 2017; UN CRPD 2007), a significant component of social inclusion, it is reasonable to conclude that in this regard, women such as Sally and Molly embody what it is to be socially excluded.

In viewing these circumstances in light of the needs-based model, several connections are evident. First and foremost is the priority for the *identification of cognitive disability* through evaluations that do not rest on the results of IQ testing. As Chapter 5 noted, IQ testing can be inconsistent and unreliable and does not provide an indication of functional capacity. Court officers and legal representatives benefit from information pertaining to cognitive disability—it is crucial if they are to help the women navigate CJS processes. This is certainly an area that has the potential to be covered by *external support services*, with organisations such as Legal Aid or equivalent agencies adequately funded to support the women from first contact with the CJS through to court appearances where they can argue the need for alternatives to incarceration. This has implications for *psychiatric wellbeing*. The findings of Chapters 4 and 5 showed the women's uncertainty and confusion around court procedures in particular and the impact of that on their mental health. Providing them with consistent support will do much to address the high levels of anxiety experienced by this study's participants in trying to navigate a complex system that has serious long-term implications for them, including loss of children, loss of freedom and compromised mental health.

7.6.4 Situational factor: "What the fuck? I have to come to gaol for you to help me?" (Susan): The impact of prison as a refuge

There were many defining moments during this research. However, it would be fair to say that Susan's observation was pivotal in encapsulating much of what is wrong with our communities. Susan suffered extreme abuse at the hands of her mother; she was homeless; her children were taken by CPS; she was addicted to ice and heroin, the reason for her custodial episodes. Susan

talked about the fact that she had begged for help "on the outside" but received none. During her time in prison, she was placed on the methadone program and her goal was to be able to come off this as well. She received counselling for her addiction, and medication for BPD. She felt healthy. Over and above interventions targeting her substance misuse and mental health problems, she ate (mostly) healthy food and was amazed at the difference this made to her overall wellbeing. She was introduced to a family violence counsellor on the day that her interview for this research took place. Until that point, she had never told anyone about the beatings received at the hands of her mother because she did not realise that such abuse was considered domestic violence.

Susan's comment, "What the fuck? I have to come to gaol for you to help me?" was a revelation – she was absolutely right. It seemed incongruous that a woman with a cognitive disability and comorbid needs had to be incarcerated to obtain help for addiction, to receive appropriate medication for a diagnosed mental health condition, be given food to eat, be provided with a roof over her head and receive support in coping with violence administered at the hands of an abusive parent. No study participant had *ever* received help to escape from, or deal with, the trauma of abuse, particularly childhood abuse. A lack of community or institutional support to change their circumstances resulted in cycles of CJS interventions, particularly multiple custodial episodes. For some, prison itself offered reprieve from abuse, as well as an opportunity for counselling, highlighting again the incongruity of prison as the provider of services that should be available in the community setting. The words of various scholars (e.g., Bartels et. al. 2019; Carlton and Baldry 2013; Carlton and Segrave 2011; Segrave and Carlton 2010) identifying the juxtaposition between prison as a place for punishment and prison as a 'safe space' were illuminated by Susan's incisive remark.

In the context of the needs-based model, Susan's experience of prison has a more positive outcome than the majority of the other women. She received treatment for BPD, withdrew from drugs, was physically removed from abuse and had food and shelter. The problem for Susan, and others like her, was that these interventions ceased when she exited prison, which was happening shortly after the time of her interview. In fact, the only determination about her future post-prison was that she had two night's accommodation in a motel. Beyond that, she had no idea what she was going to do or even where she would be at the end of those two nights. This is where *external support services* are critical in ensuring that throughcare begins in prison and continues in the community. Resourcing the services to help Susan, such as housing and accommodation, employment, drug and alcohol counselling, anger management and adaptive skills, is the way forward if reducing reoffending by reducing the reasons for it is the goal.

7.7 Theoretical reflections and concluding remarks

A point consistently made throughout this dissertation relates to societal and institutional responses to women who present as 'difficult' and what that means in terms of not just past experiences that have affected where they are now, but what their futures are likely to be. There is no question that the prison practitioners who contributed to this study understand the histories of the women and the role those histories have played in their incarceration. However, at the time this research was conducted, the type of community and institutional supports required to address offending arising from a myriad of intertwined issues were simply not available.

Molly's statement, "It's not fair" summarises the complexity of a situation that for many of the women was in place before they were born, forecasting a future marked by lack of resources, lack of opportunity and a lack of respect and self-worth. Most of the women had their own understanding of 'respect', and in fact, it was a word that featured prominently in their narratives. For them, they understood 'respect' in the context of the prison, noting that the prison psychologists particularly treated them with respect. Again, the notion of the prison providing something denied to them in the community was tinged with more than a little sadness, highlighting a situation in which respect must be 'earned' and is not automatically bestowed for reasons of humanity. Advocacy helps, but until there is major shift away from 'punishment' towards 'investment in people', very little will change for the women who took part in this study.

This dissertation provides evidence of the mutually reinforcing links between 'social exclusion' and 'incarceration'. However, recognising the links and asking *why*, in an enlightened era, these links are maintained yields a multifaceted answer. In 1965, the publication of Foucault's *Madness and Civilisation* provided an understanding of exclusion that revealed the cultural, legal, political and philosophical constructs that propagate and preserve social exclusion. In a similar vein to Goffman (1961, 1963), Foucault exposed the unpleasant truth of exclusion, the creation of human beings as either subjects or non-subjects. Several of Foucault's contemporaries (e.g., Lenoir 1974; Klanfer 1965), in documenting the rise of social exclusion in Europe, observed that at that time, prevailing attitudes to social exclusion could best be viewed as a lack of responsibility on the part of individuals who failed to conform to socially accepted goals of wealth creation and economic progress, and that being excluded was a problem of individual responsibility.

There has clearly been a softening of that position in places such as Australia, Europe and the United Kingdom. These regions have created Social Exclusion Units focused on developing

evidence-based policies designed to encourage societal and institutional practices that are more inclusive. Nevertheless, the reality is that despite general recognition of the deleterious effects of exclusion, the gap between 'the included' and 'the excluded' continues to widen. Poverty is certainly a significant contributor to social exclusion, but experiences of exclusion are not confined to income deprivation. Our systems of health and education privilege those with resources; employers favour those who are educated; acquiring accommodation most often depends on an income stream. LaBonte (2004: 120) states that "our concern, then, should not be with the groups or conditions that are excluded, but with the socio-economic rules and political powers that create excluded groups and conditions, and the social groups who benefit by this".

Those who are excluded are pathologised, albeit with good intent, yet still a 'polite' version of Lenoir (1974) and Klanfer's (1965) analyses of keeping the individual at the centre of addressing the question of *why* they are excluded. To look to the institutions that are bastions of our society and hold them accountable for systems that overtly exclude, that maintain inequitable practices marked by discrimination, that stigmatise on the basis of race, gender, and/or disability, and to acknowledge that this is a situation that must change is to suggest a complete rebalancing of the axis on which our society revolves. It is too hard for most people to imagine. Focusing on the individual and their shortcomings is therefore the preferred alternative, and the CJS does this exceptionally well.

This is the case for the women in this study. Our society, our institutions, have failed them. They have been defined by cognitive disability, by poor mental health, by substance misuse, by poor parenting and dysfunctional families, by homelessness, by Indigeneity and by challenging behaviours. The vast majority of study participants have been criminalised for being socially excluded. They have also been socially excluded because they have been criminalised. They are labelled 'repeat offenders', but this is closely aligned with 'repeat exclusions'. As Tom Calma (2008: 30) states, "without some rearrangement of the way we respond to the most vulnerable people in our community there is a risk that they will effectively be excluded from a range of services and will continue to enter the criminal justice system unnecessarily".

Guthrie et al. (2013) point to the ceremony and fanfare associated with the opening of new prisons in Australia, which simultaneously celebrate the economic benefits to communities in which the prisons are placed along with fulfilling the greater responsibility of 'public safety'. The language is invariably celebratory, with no recognition given to the bleakness associated with a rapidly expanding prison population, or acknowledgement of the money spent on a system that, by any standard of measure, is a dismal failure. In the speeches that accompany

such grand openings, self-congratulatory language along the lines of 'growing prisons' to keep abreast of the anticipated escalation in prisoner numbers is rarely juxtaposed with the *reasons* for the increases. The words of Ogden (2001: 13) offer a simple rationale as to why and who is criminalised: "My crime—being addicted to alcohol and drugs. My crime—being a survivor of domestic violence. My crime—being a survivor of incest".

The situation is complex. Each of this study's participants require a range of *coordinated* support services. Often this involves financial input and/or robust advocacy from family or friends which, for the most part, is not forthcoming. Agencies such as mental health and disability services, education and employment, housing and accommodation, children's services and community health centres function independently of one another with well-established boundaries of obligation and accountability that lack flexibility (Hamilton 2010; Baldry and Dowse 2013). As Hamilton (2010) and Baldry and Dowse (2013) identify, people with complex needs who do not have family support or some form of advocacy and who are unable to access appropriate services, mostly because they do not know about them, are vulnerable to early and ongoing interactions with the CJS (also see Hayes 2012). Without integrated and coordinated community services that operate via an outreach system of delivery, this group of women are destined to repeated cycles of incarceration. The discussion of *external support services* (Figure 15) emphasised a prime opportunity for change in Australia through the NDIS. The significance of this cannot be stressed enough. The concept of well-funded, coordinated services that work cooperatively to support this group of women is extraordinary and represents a way forward that casts their futures in a completely different light.

The results of this research have, as hypothesised in Chapter 1, demonstrated that social exclusion contributes to the trajectories of women with cognitive disabilities into prison and continues to manifest within the prison setting through institutional protocols that marginalise women with compromised cognition. This dissertation has advanced social exclusion paradigms by developing a model of social exclusion based on domains applicable to the state of incarceration. In doing so, the multifarious nature of social exclusion and the interconnectedness of both the domains and the indicators within them were revealed. Using the findings of Chapters 4, 5 and 6, a list of evidence-based needs was created, with links between those needs and the domains of social exclusion illustrated by the models presented in this chapter. Although the research findings and the models of social exclusion developed for this research may vary in other settings, it is a reasonable supposition that the domains and indicators of social exclusion pertinent to this study, have application to women's prisons in other Australian jurisdictions and further afield.

Future research on social exclusion in the context of incarcerated women with cognitive disabilities, may seek to test the theories and principles that underpin the models created for this dissertation. For example, what can the concepts explored in this research tell us about cognitively disabled women in different environments, not only in other women's prisons, but alternative domains such as community corrections? Are these theoretical findings transferable? If so, do they further CJS practices in terms of creating better outcomes for criminalised women with cognitive disabilities? The models designed for this study have broad application, and can be used to develop programs that address the needs of not just the women who took part in this study, but other women, in other prisons, in other jurisdictions. These programs should then be evaluated to determine their effectiveness, or to instigate modifications that increase effectiveness. Program evaluation is another research avenue, critical in terms of disseminating knowledge of program efficacy.

Given the narratives of participating prison practitioners, and crucially, those of the women who took part in this study, the impetus to instigate change that moves towards a state of inclusion, is augmented by the knowledge that such change has the potential to be transformative, not just in these women's lives, but in the lives of other women who also occupy a space at the margins of society.

7.8 A final word

In reading the various submissions to the National People with Disabilities and Carer Council *Shut Out: The Experience of People with Disabilities and Their Families in Australia* (2009: viii), I was struck by one particular contribution that encapsulated within several sentences the deep-seated desire expressed, perhaps not as articulately but with equal passion, by the wonderful women who participated in this study. I would like to conclude this dissertation by sharing those words:

> Perhaps we will begin to feel better about ourselves, to come to know ourselves as honoured, respected, accepted, yes, loved. To be healed from shame, feeling unworthy, undesirable, ugly, difficult, not smart enough, not sporty enough. And perhaps we might be freed from our terrible daily fears that it all won't last, that more rejection is written into our lives. Maybe our dreams will no longer be filled with the traumatic fear of others pushing us around.

Appendices

Appendix 1: Interview schedule: Women participants

Informal networks – outside prison

* denotes related elements

Where did you live when you were little? Provided information about geographic locations, types of housing, stability/instability of accommodation, how often they moved and where they moved to. Some Indigenous participants spoke about their communities.

Who lived with you? Provided information about parents and siblings, as well as other people who may have lived with them (e.g., non-biological partners of parents).

How did you get on with your family? Provided information related to several different factors—dysfunctional families, childhood and teenage abuse, substance misuse and familial deaths. Information was also sought about positive family relationships, both past and ongoing.

*trust and safety *health and wellbeing

Do you have a partner? Provided information about the experience of domestic violence and substance misuse, as well as partners who had been/continued to be supportive.

*trust and safety *health and wellbeing

Has anyone from your family ever been in prison? Provided information about familial and partner incarceration and criminal activity leading to this.

Do you children? Provided information about parental status and children's primary carers.

*formal networks (e.g., CPS).

Did you have any friends who were special? Provided information about peer relationships and bullying.

Did you have hobbies, or did you play sport? Provided information about community involvement and personal interests.

*civic engagement

Do you have some happy memories from outside prison that you'd like to share? Provided an opportunity to reflect on positive aspects of life outside prison.

Formal networks – outside prison

* denotes related elements

Did you go to school? Provided information about what type of school they attended (e.g., special school) and attitudes about going to school

*informal networks (e.g., role of family in supporting/not supporting education)

What things did you like/dislike at school? Provided information about interest in subject areas, peer associations, bullying and participation in school activities.

*trust and safety *informal networks (peers)

Did you have a favourite teacher? Provided information about school staff care and engagement with, and attitudes towards, teachers.

*trust and safety

How long did you stay at school? Provided information about educational attainment and school attendance, and circumstances leading to exit from school.

What did you do when you left school? Provided information about employment histories, and 'gateways' to criminal activity

Did you ever live in a foster home? Provided information about circumstances leading to placement in state care, foster home environments (e.g., abuse)

*trust and safety *health and wellbeing *informal networks (family)

How do you get along with the police? Provided information about the nature and frequency of interactions with police, over- and under-policing, police responses to domestic violence, susceptibility to coercion (a) to commit crimes (b) during police interviews

*trust and safety *informal networks (family, peers)

What was your experience of going to court like? Provided information about legal representation, particularly the way in which processes were/were not explained,

understandings of what was happening prior to and during court, the granting/not granting of bail, attitudes of court officials

*trust and safety

Did someone help you in court? Provided information about the provision of a support person (e.g., ALO or communication partner).

*trust and safety

Have you ever been to juvenile detention? Provided information about age at which offending began, how many times they were detained, nature of offences that resulted in juvenile detention, length of stay in a juvenile facility, what they remember about being in 'juvy' (juvenile detention), whether they felt safe, if they were bullied, if they made any friends, and whether family visited or contacted them by phone, letters or cards.

*trust and safety *informal networks (family, peers)

Informal networks – inside prison

* denotes related elements

Are there other women you get along with? Provided information about interpersonal relationships within the prison, whether the notion of 'friendship' has relevance in the prison setting, and if friendship is similar to or different to friendship outside prison. The question prompted conversation related to issues of bullying and susceptibility to coercion, especially behaviours inciting custodial officer interventions and potential sanctions, and acquiescence to handing over money.

*trust and safety

Do you have visitors? Provided information about prison visitation and whether the women viewed this in a positive or negative light, particularly visits from children and the impact of separation from them. Provided information about prison visits by partners and other family members, as well as friends.

*informal networks (family, friends) *health and wellbeing (mental health)

Do you talk on the phone to your family and friends? Provided information about regularity of contact with children, family and friends as well as perceptions of costs associated with prison phone calls and outside assistance/lack of assistance to pay for these.

*informal networks (family and friends) *health and wellbeing (mental health)

Do you receive letters or cards? Provided information about birthdays and Christmases spent in prison, prison rules regarding photos in cells, prison monitoring of incoming and outgoing mail and the women's capacity to maintain connections with children through cards and letters.

*informal networks (family and friends) *health and wellbeing (mental health)

Formal networks – inside prison

* denotes related elements

What was prison reception and induction like for you? Provided information about transfers to prison from police and court watch-houses and feelings upon arrival in prison (some women spoke about strip searches).

*trust and safety *health and wellbeing

Do you think there are ways it could be better? Provided opportunity to talk about prison staff attitudes upon arrival, the sorts of questions they were required to answer, whether everything was explained clearly and how these processes could be changed.

*trust and safety *health and wellbeing

How do you get along with the people who work in the prison? Provided information about relationships with custodial officers, practitioners (e.g., psychologists), medical practitioners and counsellors, and perceptions of power/authority, fairness/unfairness, respect/disrespect, trust/distrust. This also provided information about perceptions of practitioner interventions with issues such as mental health and substance misuse, and prison regimes for accessing medical and dental practitioners.

*trust and safety *health and wellbeing

What things do you do each day? Provided information about engagement with activities relative to security rating (e.g., boredom in solitary confinement, access to exercise, activities for lower security such as fitness and sport, arts and crafts).

*health and wellbeing *agency

Have you participated in any programs? Provided information about availability and suitability of programs, desire to participate, perceptions of program benefit/lack of benefit, program waiting lists, program facilitators and relevance of program to life outside prison.

*agency

Do you have a (prison) job? Provided information about attitudes to work, types of jobs undertaken, trust of prison staff (to do the job well), being paid to do a job, perceptions of self in relation to the job (e.g., sense of contribution to others by performing the job well) and potential to do a similar job outside prison.

*agency *trust and safety *civic engagement

Trust and safety – outside prison

* denotes related elements

Before you came to prison, were there times that you didn't feel safe? This provided information about unstable domestic arrangements, neighbourhood areas in which they felt unsafe, peers who made them feel unsafe, foster care, homelessness, interactions with police, being locked up in police cells and/or court watch-houses and being released on bail.

*informal networks *formal networks

Did you ever experience bullying? This was generally covered in 'informal networks' (see above), but its inclusion provided an opportunity to talk their attitudes to bullying (e.g., not only if they had been bullied, but if they had bullied others and why). It also provided information about levels of trust in formal networks such as education, health, housing, police and court personnel.

*informal networks *formal networks

Were you ever frightened? Although this might seemingly have been covered by several of the previous questions, information was provided about more random feelings of fear arising from situations such as catching public transport, going to the doctor or to hospital, walking alone, being in a house by themselves, fear of coming off substances, fear of recommencing addictive behaviours post-prison, fear of leaving prison (especially if they had previously been in an abusive relationship) and the fear associated with having their children removed by CPS.

*informal networks *formal networks

Did the police ever help you? This provided information about the women's perceptions of police in circumstance other than those related to police interventions and arrest. Police assistance with homelessness, domestic violence and situations such as being lost as children asked the women to consider positive policing roles.

*informal networks *formal networks

Did you know where to go to get help if you were unsafe? Although related to the previous question, this provided information about knowledge of women's refuges, homeless shelters and services for those who are homeless, community safe houses and knowing which people or what agencies to contact for help.

*informal networks *formal networks

Trust and safety – inside prison

* denotes related elements

Do you feel safe here? This provided information about overall feelings of safety in the prison, and whether they felt safer inside or outside the prison, and why.

*informal networks *formal networks

Are there any areas of the prison where you feel unsafe? This provided information about specific areas of the prison in which the women did not feel safe, the reasons for this and whether they had spoken to a staff member or other prisoners about this.

Do you think people respect one another? This provided information about the women's understanding of 'respect' and whether they experienced respect/disrespect from prison staff and other prisoners. It also provided information related to matters of human dignity, kindness and issues of self-esteem/self-respect. The question invited comments about coerced behaviour, such as verbally and/or physically abuse of staff.

*formal networks *informal networks *health and wellbeing

Has anyone asked you for money? This provided information about issues of vulnerability and acquiescence, and the circumstances in which the women gave money to other prisoners and/or handed over purchases made from the prison canteen. The women also commented on whether they received help and support from anyone if this happened.

*formal networks *informal networks

Do you think there are things that could be done to help you feel safer here? This provided an opportunity for the women to offer suggestions about how they could feel safer in the prison setting (e.g., mentor schemes, seeking help from staff they trust)

*formal networks

Health and wellbeing – outside prison

* denotes related elements

Do you feel that you were healthy before you came to prison? This provided information about self-perceptions of health, and engagement with health services.

*agency *formal networks

Did you exercise? This provided information about attitudes to exercise and participation in sporting activities.

*agency *civic engagement *informal networks

Did you use drugs? Did you drink alcohol? This provided a wide range of information about drug use, particularly the circumstances in which the women were introduced to drugs. It also provided additional information about the role of drugs in their offending, whether incarceration has helped with not using drugs, the impact of drugs on retaining custody of their children, and if they abstained when released.

*informal networks (family, peers) *formal networks (CJS, CPS)

Did any of your family use drugs or alcohol? This provided information about the intergenerational nature of substance use and the impact of this within the family domain, particularly CPS and CJS interventions.

*informal networks (family, peers) *formal networks (CJS, CPS)

Were you a smoker? This question provided information about age smoking commenced, whether coming to prison has helped them to stop and if smoking has caused any health-related issues.

*informal networks (family, peers)

Have you experienced times in your life when you feel sad? This provided information around the issue of mental health, causes of depression/anxiety, pharmacological interventions and

interactions with mental health professionals. It also elicited information about family mental health and the impact of this in terms of the role of CPS in their lives, and that of their children.

*informal networks (family, peers) *formal networks (CJS, CPS)

What did you do if you were feeling sad? This provided information about personal responses to mental health, such as self-medicating, drug and/or alcohol use and peer associations.

*informal networks (family, peers)

What things made you feel good about yourself? This provided information pertaining to self-respect and self-esteem by asking the women to reflect on people they knew, things they had done or things that had happened gave them a sense of satisfaction and happiness.

Health and wellbeing – inside prison

* denotes related elements

Has coming to prison changed your health? This was a broad question that provided information about self-perceptions of mental and physical health by comparing 'outside' health' with 'inside health'.

*formal networks (prison health services)

Have you seen the doctor here? This provided information about medical interventions in prison, and the processes involved in accessing a doctor.

*formal networks (prison health services)

Who do you talk to if you're feeling sad or upset? This provided information about mental health issues and how they are addressed in the prison setting. The women could speak about their relationship with psychologists/counsellors, the implications of family contact/non-contact and whether they confided in other prisoners.

*informal networks (family, peers) *formal networks (prison therapeutics)

When in a cell by yourself, do you feel better or worse? This provided information about experiences of solitary confinement and the impact on mental health, including self-harm.

*formal networks (prison staff, for example, custodial officers and prison therapeutics)

Do you do exercise? This provided information about exercise as a priority or not, what kind of exercise and where this took place, if they exercised alone or with others, and whether they exercised more or less since coming to prison.

*agency *informal networks (peers)

What things might help you to feel better? This provided information about the strategies the women felt would improve their mental and physical health in prison.

*formal networks (prison therapeutics, health services) *informal networks (family)

Agency – inside prison

* denotes related elements

How do you feel about getting out of prison? This provided information about the women's perceptions of exiting prison and what feelings this evoked (e.g., nervous, anxious, happy and/or excited).

*informal networks (family, peers) *health and wellbeing *trust and safety

Are you working towards anything like a lower security rating? This provided information about in-prison plans that the women were either doing/planning on doing, aimed at facilitating an exit from prison (e.g., working towards a different security rating).

*formal networks (prison programs and counselling)

Do you think you'll see your family and friends when you are released? This provided information about the women's perceptions about peer and family influences in their lives post-prison (e.g., re-attaching to criminogenic peers/family) and whether this would be good/bad.

*informal networks *trust and safety

What things would help you in the community? This provided information about aspects in the community that had *not* helped the women prior to incarceration, inviting them to reflect on how that could be changed, and what things they felt were important to help prevent reoffending.

*informal networks (family, peers) *formal networks (drug and alcohol counsellors, engagement with CPS) *health and wellbeing (mental/physical health clinics) *trust and safety

Where you will live when you leave here? This question provided information about living arrangements immediately after exiting prison, as well as more long-term living arrangements.

*informal networks (family, peers) *formal networks (government/NGO housing) *trust and safety

What sort of job would you like to do? This question provided information about possible work options, intent to work/not work and avenues for obtaining employment.

*formal networks (Centrelink, employment agencies) *civic engagement

What gives you hope for the future? This question provided information about perceptions of life after prison beyond descriptions of housing and employment to incorporate aspects such as better mental health, having money, being with children and family, going on a holiday, and being liked and respected.

*informal networks (family, peers) *health and wellbeing **absence* of formal networks (e.g., police, CJS, and CPS)

Civic engagement – inside prison

* denotes related elements

Do you think your job helps other people? This question (asked of women with a prison job) provided information about how they viewed their job in terms of its contribution to the prison environment. It invited reflections on issues of self-respect and self-worth, and the respect extended to them by others, such as prison staff.

*informal networks (peers) *formal networks (prison staff) *agency

Why were you prepared to help me with my project? This question provided information about the women's reasons for participating in the study, as well as an opportunity to reflect on broader outcomes of research participation.

*agency

Appendix 2: Interview schedule: Prison practitioners

Informal networks – outside prison

What were the family circumstances of (name)? Where did they live?

Which [Indigenous] community does (name) come from?

What things do you consider contributed to experiences of trauma?

Does (name) have a partner? What is the nature of that relationship?

Is there a history of family and/or partner incarceration?

Does (name) have children? Who cares for them?

For children in foster care, what do you believe is the likelihood of (name) regaining custody?

Could you comment on the issue of vulnerability and acquiescence, particularly in relation to substance abuse and criminal activity?

Formal networks – outside prison

What information do you have about the schools (name) attended and how far they went at school? Are they literate?

Did they attend a special school at any point in their education?

Are you aware of any employment, training or further education (name) may have undertaken when she left school?

Was (name) ever in state care?

Do you have any further information about the circumstances that led to this, or about the nature of the placement?

What have (name's) interactions with police generally been like?

To your knowledge, what circumstances have resulted in police interventions?

Have they ever been issued with a police caution?

For what crimes have they been arrested?

Has (name) ever received bail?

Has she had legal representation in court?

What in general have been court outcomes (released on bail, remanded in custody)?

For what crimes have they been convicted?

What is your view about court processes for those with cognitive disabilities?

What do you see as alternatives?

Has (name) ever spent time in a juvenile facility?

Why was this? For how long?

Informal networks – inside prison

Does (name) have any friends amongst the other women?

Have you observed their interactions?

To your knowledge, has coercion in either money matters or antisocial behaviour been an issue?

Does (name) receive visits? Who from? How often?

Do you have knowledge of how those visits go?

Do they see their children?

Does (name) use the phone? Who do they call?

Do they pay for the calls themselves or do family/friends help with this?

Do they speak to their children on the phone?

Do you know if (name) has received letters or birthday/Christmas cards?

Do they have photos of their children in their cells?

Formal networks – inside prison

What kind of testing or assessments were carried out when (name) entered prison?

Were similar tests conducted for previous custodial episodes?

Did you notice any difference between that time and this?

How did (name) cope with the strip search? Was anything found?

Do you have an opinion about the use of strip searches?

What issues are you currently working on with (name)?

How often do you see her?

What is the nature of her mental health disorder(s)?

Is substance misuse a contributing factor?

What interventions have been undertaken?

Has (name) participated in any programs? Which ones?

Did she complete them?

Do you think they were of benefit?

Did she receive additional help with the program content?

Does she participate in education?

Does (name) have a (prison) job? What is it?

How often does she go to work?

Do you think she enjoys working?

How long has she had this job?

Has she had a job during previous custodial episodes?

If (name) doesn't have a job, why is this?

Has she ever had a prison job?

Is it likely/unlikely she will have a job during this term of incarceration?

How does (name) cope with court appearances via video link?

Does anyone support her during this process?

How does she react with the postponement of court dates?

Has this happened often? Why?

Trust and safety – outside prison

Are you aware of what circumstances led to (name) being homeless?

Has she ever talked about having anyone she could trust?

Do you know if she has been a victim of bullying?

Were her family/domestic arrangements the main reason she felt unsafe?

Was substance use a contributing factor to her lack of safety?

Trust and safety – inside prison

Do you think (name) feels safe in the prison setting? Why is this?

Are there custodial officers she doesn't trust? Or any other staff (e.g., prison doctors)?

Are there other prisoners (name) is frightened off?

Has she been bullied?

What is the prison's response to this?

Has she ever mentioned areas of the prison she is too nervous to go to?

Has she been coerced into giving up her money/purchases?

Has she been coerced into acting out and breaking rules?

Do you address the issue of coercion with her? In what ways?

Has (name) ever had a mentor who is also a prisoner?

Was this successful? Do you think it is a strategy that has merit for women with cognitive disabilities (pros/cons)?

Health and wellbeing – outside prison

Do you know of any physical health issues that (name) had when she came to prison?

Has the prison addressed those?

Do you think there has been an improvement?

Was she a smoker?

Has (name) received a mental health diagnosis from agencies outside the prison?

What did they state were the main issues?

Were there any interventions initiated by outside doctors or mental health practitioners? Over what period of time?

Have there been any interventions for substance misuse? By whom? Over what period of time?

Is there a history of substance misuse in (name's) family? Her community?

Is there a history of mental health issues in her family?

Health and wellbeing – inside prison

Have you seen an improvement or decline in the physical health of (name) since she has been in prison? Has the prison put in place any protocols to help with, for example, cardiovascular disease, emphysema, asthma, arthritis, and/or obesity?

Do you think (name's) mental health is better or worse since coming to prison? Why? Does (name) self-harm? How often does this happen? How does the prison address this? How often do you work with (name)?

How does she cope with solitary confinement? What is your opinion of solitary confinement as a strategy? Does (name) receive pharmacological interventions?

Agency – outside prison

Do you envisage that (name) will be able to work once she leaves prison?

What do you see as the barriers to this?

What would be needed to facilitate her work opportunities?

Are there any accessible and suitable programs in the community that you are aware of to help with substance misuse, parenting further education or job training?

Do you have an idea of where (name) will most likely live when she leaves prison?

Will there be any restrictions on which family/peers (name) is allowed to socialise with when she leaves prison?

In terms of life skills, what do you consider to be the priorities for (name) remaining safe and well?

Agency – inside prison

Does (name) work?

If not, what do you see as the barriers to this?

What would be needed to facilitate prison work?

Has (name) committed to doing any of the prison programs? Has she discussed this with you?

Are these programs suitable for her in terms of the level at which they are pitched?

Would participation in the parenting program be helpful for (name) regaining custody of her children?

How appropriate are educational programs for (name)?

How do you address the issues of coercion and acquiescence?

In terms of life skills, what do you consider to be the priorities for (name) remaining safe and well?

What are the pitfalls for (name) when she exits prison?

Will there be restrictions on family/peer associations post-prison?

What do you feel are the community supports necessary for her to succeed?

What is the process for getting (name) access to the NDIS?

Civic engagement – outside prison

Are you aware of any community activities in which (name) participated?

Has (name) ever been in a primary carer role other than her children?

Has (name) ever talked to you about hobbies or activities she might have done prior to incarceration?

Civic engagement – inside prison

What is (name's) attitude to her job?

Is she happy to work, or does she work because she has to?

Has (name) ever talked about doing volunteer work?

Could (name) do the RSPCA program?

What, if any, are the barriers to this?

Appendix 3: First round coding themes

Socioeconomic background

Dysfunctional families

Family violence

Child sexual/physical abuse

Grief and loss

Intergenerational and/or family incarceration

Foster care

Displacement and isolation (Indigenous communities)

Juvenile detention

Friends/peers

Sport and recreation

Education

Bullying

Employment/unemployment inside/outside prison

Parental status

Women's children in foster care

Homelessness

Mental health

Physical health

Self-harm

Substance misuse

Police interactions

Experiences of court

Victim–offender nexus

Prison visitation

In-prison contact with family and friends

Access to money

Prison programs

Elders

Beyond prison

Appendix 4: Second round coding: Linking indicators with domains of social exclusion

Informal networks – outside prison

Family

Peers

Community participation (e.g., sport)

Informal networks – inside prison

Other prisoners

Prison visits

Phone calls, letters

Formal networks – outside prison

Education

Employment

State (foster) care

CJS (police, courts)

Formal networks – inside prison

Prison intake

Remand

Prison staff

Program participation

Employment

Children in state (foster) care

Trust and safety – outside prison

Trauma (e.g., child abuse, adult abuse, family and domestic violence)

Unstable accommodation, homelessness

Interactions with police

Trust and safety – inside prison

Other prisoners

Prison staff

Legal representatives

Accommodation (e.g., solitary confinement)

Access to Elders

Health and wellbeing

Substance misuse

Mental health

Self-harm

Physical health

Agency

Program participation

Pre-release planning

Civic engagement

Research participation

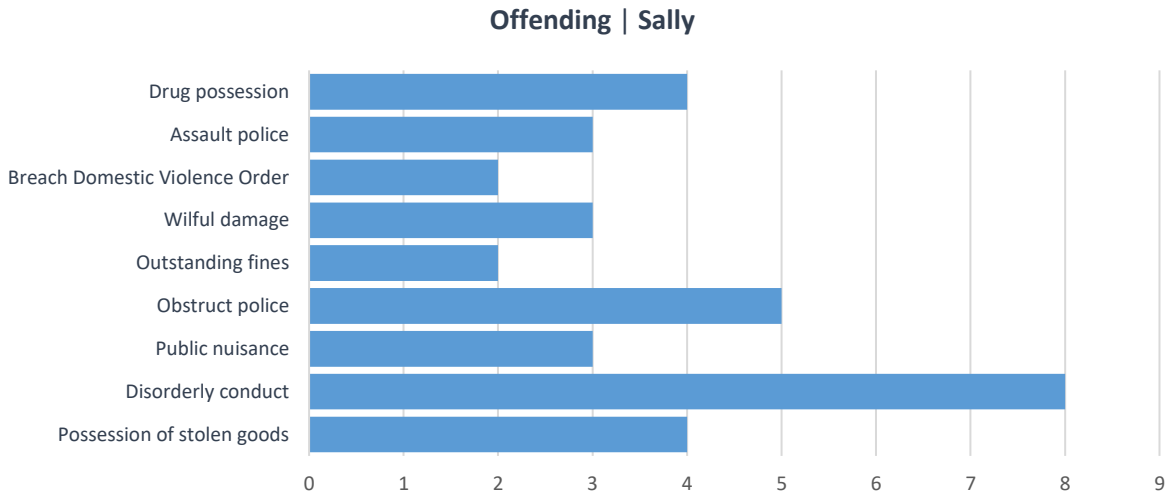
Prison employment

Appendix 5: Biographies of the women participants

Sally (28, Indigenous)

Background: Sally comes from a small community that is very volatile. Many of the residents' descendants suffered forced removal from their community to mission stations. The economy is failing, mostly due to high unemployment. There are numerous historic clan issues, with people brought in from other communities giving rise to significant tension and fighting between Elders, further destabilising the community. A very high rate of child removal is ongoing, and while the rates have fallen since the 1980s, it is a practice that remains in place, undermining the cohesion and solidarity of the community and its families. A government-sponsored alcohol management program operates, whereby alcohol is issued via a canteen arrangement, but the community is not 'dry' as such.

Sally's offending history



Sally's life: Sally's cognitive disability was identified by the school she attended. She is under the care of the Guardianship Board, Public Trustee and Mental Health Services. She has had numerous interactions with the CJS dating back to 2007. She has received numerous fines, with Community Service Orders (CSOs) issued when she was unable to pay them.

Sally suffered physical abuse at the hands of her family. She was 'passed around' within her community who did not understand that she was cognitively impaired. By the age of 10, she was regularly using alcohol and cannabis, which impacted significantly on her decision-making abilities. She assaulted her mother and sister because they bullied her and, at the time of interview, was remanded in custody because of this, along with charges of drug possession, assaulting police and public disorder.

Violence is a part of Sally's community and she learned at a young age that if you want something, the way to achieve it is via the use of physical aggression. Despite community violence, Sally maintained that she 'felt safe' and protected. She recalled happy times fishing with her father and cooking the fish to share with family. She loved walking on the beach and swimming with her cousins, nieces and nephews. Sally has no children of her own.

At the time of interview, several of Sally's family members were incarcerated. Her (male) cousin is serving a life sentence for murder. Another cousin and an aunt were also in prison with Sally. Because of the remoteness of her community, Sally receives no family visits and no phone calls.

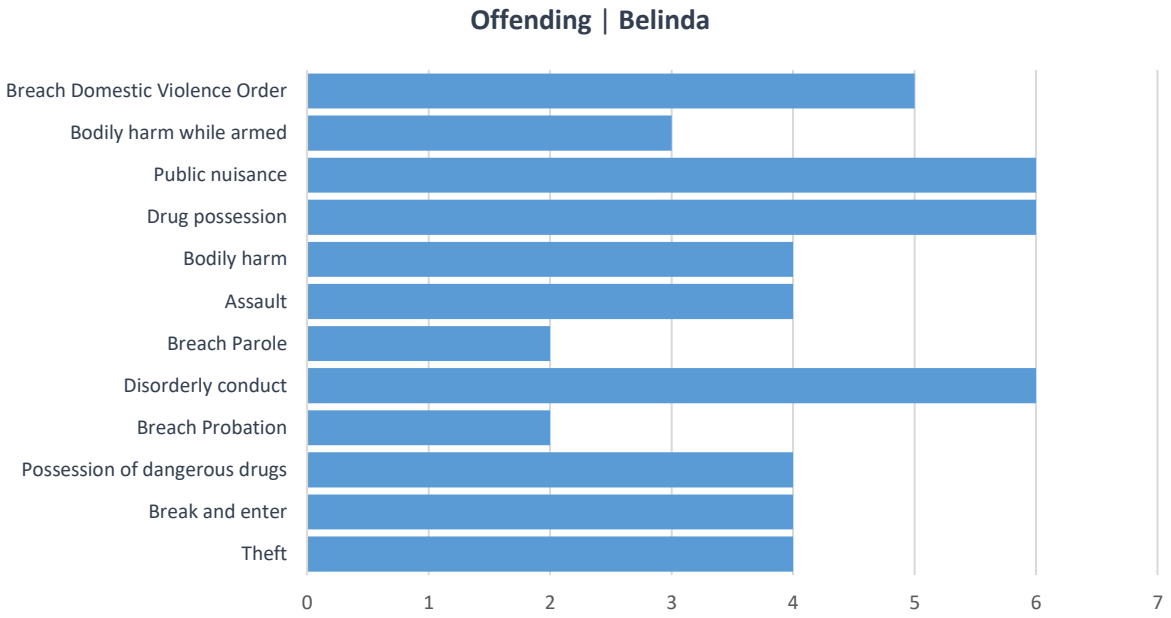
Other prisoners take advantage of Sally. She is very vulnerable and is an 'easy target' in the prison population. This applies particularly to her finances. The Public Trustee sends her money which the other prisoners take from her. She has worked in the prison as an outside cleaner for which she earned a little extra money, but other prisoners bullied her, forcing her to use the money to purchase things for them from the prison canteen. She has significant mental health problems and the potential for violence. Sally 'talks on the phone', although there is no one on the other end and conversations are make-believe.

Her greatest wish is to return to her community.

Belinda (33, Indigenous)

Background: Belinda comes from a remote community but is not in contact with either her family or community. When she was 15, her older sister, with whom Belinda was very close, hanged herself, and this had significant and ongoing ramifications for Belinda's mental health. She has two children, both of whom are in foster care. The children's father has substance abuse problems, as does Belinda, and it is unlikely that either will regain custody of the children. Belinda's disability was identified outside of Corrective Services. She has been diagnosed with schizophrenia. As a result of non-compliance with taking medication while in her community, a treatment order was issued by the Mental Health Tribunal. She now receives fortnightly medication.

Belinda's offending history



Belinda's life: Belinda's substance abuse began at a young age when she was introduced to alcohol and marijuana, both of which she used often. Belinda's patterns of drinking and drug use were copied—she replicated the behaviours of family and community members. Belinda was first arrested at age 13 for break and enter offences, and subsequently for more violent crimes, including assaults and bodily harm, as well as drug offences. She was never placed into juvenile detention as she was mainly issued with good behaviour bonds and CSOs.

As an adult, she has been in and out of prison numerous times, mostly due to breaches of DVOs. While she has been granted parole on several occasions, she has breached the order each time and been returned to custody. Belinda made constant reference to the police presence in her area and felt that they 'picked on her'.

Belinda's relationship with her current partner has seen her as both victim and perpetrator of domestic violence, and while she maintains that he is still in her life, he has never made contact with her during her terms of imprisonment. At the time of interview, she was incarcerated for attacking him with a knife. Belinda's resolution to all problems is to walk away from them and her comprehension that this fails to solve a crisis is limited.

Belinda has participated in short-term programs addressing substance abuse, but her goal when leaving prison is 'to have a drink'. She is settled within the prison environment and has a job as a bin-runner which she does well. Because there is structure and routine around her medication, her moods are more stable. Belinda receives no visitors or phone calls.

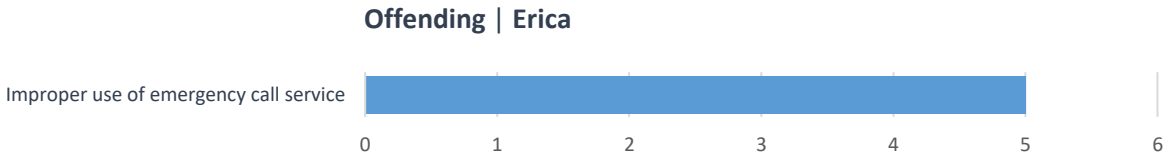
Erica (17, non-Indigenous)

Background: Erica was born in a large town, but moved to a much smaller one during her school years. She went as far as Year 9, but disliked school because she was badly bullied. She was placed in juvenile detention at age 15, which she quite liked as she was able to attend school, play sport and swim in the pool every day. This represented the longest period of sustained education in Erica's life. Her disability was formally identified by the prison psychologist via the use of the HASI in which her cognitive age was evaluated as being equivalent to that of an eight-year-old child.

Erica is one of six children and refers to herself as the "bad child in the family". Her whole family are cognitively impaired. Her father was previously fully functioning, but chronic alcohol use saw a decline in cognitive ability. He passed away when Erica was 12.

Erica started using marijuana from an early age. She has been a client of Mental Health Services, receiving help for attention-seeking behaviours. State Disability Services used to be involved, but Erica was dropped as a client due to her lack of engagement and failure to attend appointments.

Erica's offending history



Erica's life: Erica has a long history of criminal offending, mainly related to hoax 000 calls which have seen the deployment of police and state emergency services. Erica repeatedly self-harmed while in the community. Since her incarceration in an adult facility, she continues to make statements of self-harm, such as "I'm going to kill myself" which she knows will bring immediate attention from staff, particularly the psychologist. Strict protocols around expressions of self-harm require protective mechanisms to be put in place and the psychologist said that this had become a learned behaviour on Erica's part.

Erica is very childlike. When working with prison staff she likes to touch and play with their hair, clothes or jewellery and has little concept of personal boundaries. She was initially accommodated in the Safe Unit as she was frightened of the older women. Issues of self-harm also needed to be addressed. A staged integration into mainstream accommodation over several weeks meant that Erica could participate in regular activities such as having lunch there.

However, in keeping with prison regulations, Erica was strip-searched *every time* she was returned to the Safe Unit. She was a 17-year-old by herself in a cell, but in reality she was an eight-year-old locked up alone.

Erica now participates in sporting activities at the prison. She receives support from several of the other women. Some have children of their own who are intellectually around the same age as Erica. They adopt a nurturing role which in some respects helps to fulfil their own maternal instincts. The disadvantage is that Erica is 'mothered' by 15 women, which increases her dependency and inhibits her ability or will to become more independent. The other women take financial advantage of Erica, persuading her to make purchases such as lollies and chips for them.

Erica says that she likes prison. She enjoys going to education classes and is settled in the structure of prison life. She maintains that she feels safe in prison, although she has been known to lash out physically if she becomes frightened. She talks a great deal about her late father and is very sad that he is no longer alive.

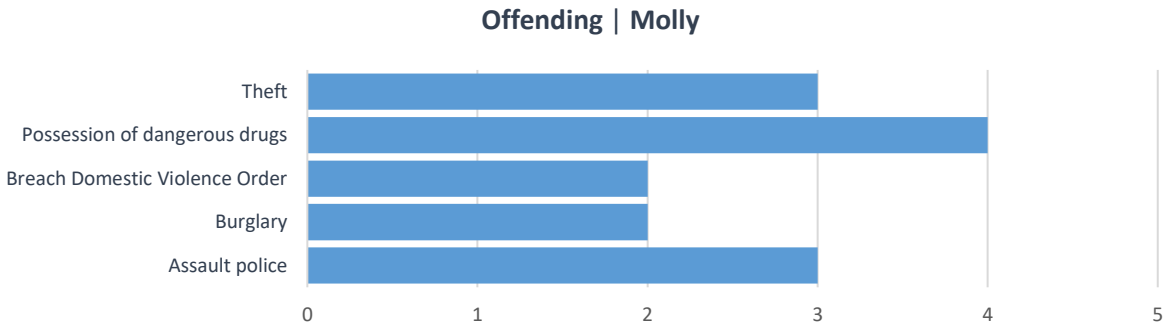
Erica has received no visits from family or friends since being incarcerated in an adult facility, although her mother came to see her in juvenile detention and brought a birthday cake for Erica's seventeenth birthday. None of her family write to her, but Erica tries to write letters to her mother. She has received a small number of phone calls from family members.

Molly (31, non-Indigenous)

Background: Molly has been homeless for several years, mostly sleeping in parks. She previously lived in halfway houses for people with substance abuse disorders. She started petrol and paint sniffing at the age of nine and her mental state has been impacted significantly by an extensive history of substance abuse. She is under a Public Trustee administrative order but believes that they take all her money. She was previously a client of the Guardianship Board, although this order ceased shortly before she was incarcerated.

The prison psychologist identified that it is extremely challenging to obtain background information about Molly. The psychologist attempted to discover more about Molly's past from the Guardianship Board, but they would not disclose any information, so there have been no definitive answers regarding Molly's parents and family, her education or where she lived as a child. Molly denies having a mental health disorder but has spent time in psychiatric units prior to her imprisonment. At one point, she spent time in a short-term accommodation operated by Mission Australia offering crisis housing and health services.

Molly's offending history



Molly's life: Because of the lack of information from the Guardianship Board and Molly's own inability to hold a line of conversation, knowledge about her past is quite limited. She has had five custodial episodes and has also been accommodated for a short period (48 hours) in the prison's secure mental health facility.

Following her latest release, Molly was returned almost immediately to prison as she was facing new charges of assault of a police officer on the day she exited prison. According to the officer's statement, she was "acting strange" and "cutting her hair in the car-park". Molly lashed out physically when he attempted to approach her. Her incarceration also relates to contravention of a DVO and drug possession.

Molly has three children, all of whom are in foster care. At the time of interview, she was pregnant with her fourth child. In response to her positive pregnancy test, she said she did not know how this could be. However, according to the prison psychologist, the pregnancy was the result of a sexual assault. Molly spoke about 'in-breeding', but it was difficult to ascertain the context for this. She also said she was going to give the baby to CPS when it was born.

Molly's dialogue about her family was confused. She referred to her mother as 'mummy' and made statements such as "Mummy stabbed the guy who raped me," followed by pulling her shirt off her shoulder to reveal a healed wound. She frequently said, "Mummy is coming to prison". The status of her mother is unclear. Molly also indicated she has a brother about whom she expressed concern, feeling that he was not safe. She was unable to elaborate as to why this might be the case. She spoke about the crimes that she is in prison for—robbery, trespass and assault. She was able to list these charges, but said several times that she had no idea as to why she is in prison.

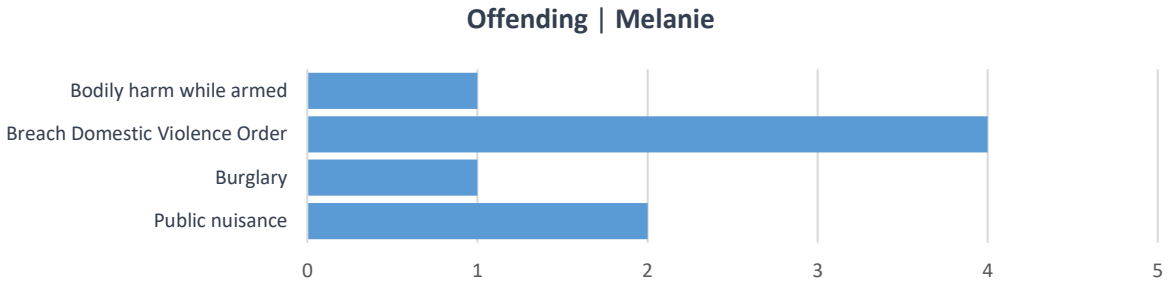
Molly is on 30-minute observations in the Safe Unit with a referral to Mental Health. Due to her pregnancy, her regular medications have been changed and at the time of interview she was

less settled and more anxious. She has elevated feelings of vulnerability and helplessness. She is worried about her brother, anxious about the drugs she is taking, in denial about her pregnancy and confused as to why she is in prison. Molly's life has been chaotic, dominated by substance abuse, sexual abuse and mental health disorders and punctuated by time spent in custody.

Melanie (32, Indigenous)

Background: Melanie's cognitive impairment stems from glue and paint sniffing that commenced when she was eight years old, ceasing when she was 15. She is aware that this is what caused her disability. She began drinking and using cannabis at age 13. At the time of interview, Melanie was housed in the low-security section of the prison where the gates are open through the day and only locked at night. She was not tempted to walk out as she knew that this would result in being returned to the Secure Unit. A DVO, taken out by her partner following an incident in which Melanie held a knife to his throat, remained in place and would be enforceable upon Melanie's release. The parole board have issued a statement of release conditions, but Melanie is reluctant to adhere to any restrictions placed on her.

Melanie's offending history



Melanie's life: Melanie is quite high functioning. She attended school until Year 11, but disliked it. However, she very much enjoyed sport and was involved in a variety of sporting activities. She admitted to being a bully at school, but maintained that this was done in defence of students who were themselves being bullied by others. Melanie's upbringing was marked by substance abuse. Domestic violence was prevalent in her community. Melanie copied observed patterns of behaviour, particularly physical violence. She grew up watching her family and community members smoking, drinking alcohol and drug-taking. She has a sister, cousins and nieces who still live in the community but who are also substance dependent. Melanie continued smoking, drinking and drug-taking while pregnant and had her first child removed by CPS because of

this. Melanie also surrendered her other two children to CPS and they have been placed with an Indigenous carer.

Melanie made little reference to her family or community, although she said that her father left them when she was born. She sees the Elders regularly and an Indigenous child support worker brings her children to the prison's playgroup once a fortnight. This is a 'double-edged sword' for Melanie, who relishes the opportunity to interact with her children, but she and the children become upset when the session ends.

Apart from her children, Melanie's thoughts and conversation are dominated by continual reference to her partner. She experiences heightened levels of jealousy around the possibility of him having other relationships, even though at the time of interview he was incarcerated for drug possession. He is an ice addict and is forbidden to have any contact with the children. Melanie has a tense relationship with her partner's mother and maintains that, "The whole family are drug addicts". She expressed feelings of jealousy about her partner's sister who "looks white" because her father is non-Indigenous. She believes her partner's mother takes more interest in the sister's children because of this.

A major component of Melanie's release conditions is that she does not have any contact with her partner. She refuses to accept this, which results in a breach of parole and a return to prison. She spoke continually about obtaining a house for her, her partner and her children when she leaves prison, seemingly unaware or unaccepting of the notion that the type of accommodation she is seeking is difficult to access, her children will remain in the care of their foster mother and she is not permitted to have contact with her partner. She speaks constantly with the prison counsellor about obtaining new beds for the children, along with books and toys that will be placed in the home ready for them when she is released.

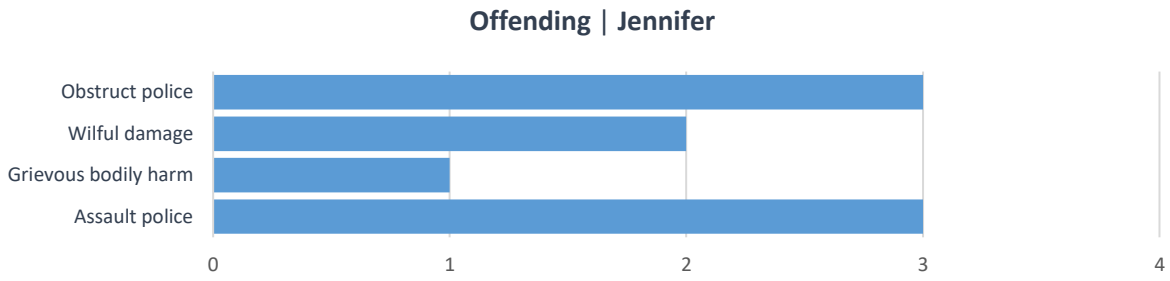
Melanie is employed at the prison on 'parks and gardens' duty, caring for the prison lawns and gardens. However, her day-to-day life is consumed with talking about her partner and her preoccupation is considered by the psychologist to be obsessive. She has difficulty eating and sleeping and feels anxious much of the time. While she said that she would be prepared to do both a parenting course and a substance misuse course, she would only undertake these after she was released. Despite frequent conversations with the other women in her unit, as well as with the psychologist, prison counsellors and visiting Elders, Melanie's partner-directed anger and jealousy have failed to subside, calling into question her ability to adhere to parole conditions when she is released.

Jennifer (Indigenous, 23)

Background: Jennifer is heavily scarred as a result of chronic self-harm. She is hypervigilant in the presence of others, believing that most people are laughing at her and making judgements about her. The prison psychologist has not formally tested Jennifer as it would confuse her, particularly if she were unable to provide an answer to a question. The psychologist believes that neither the process nor the results would add anything constructive to Jennifer's life.

Jennifer is very violent and lives in a constant state of fear due to a trauma-filled past. She exhibits elevated levels of self-protective behaviours. Her extensive prison time has mostly been spent in the isolation of the Secure Unit or Protection. Jennifer is under 'at risk' observations in a monitored cell. She uses blood from self-harming and toilet paper to cover the camera lens. Jennifer is a Public Trustee client. However, this agency has banned her from their office due to her violent behaviour.

Jennifer's offending history



Jennifer's life: Jennifer had a horrific upbringing and was physically and sexually abused as a child. Her father hanged himself, and Jennifer discovered him and was present when he was cut down. She went to live with her abusive mother who had a series of partners, all of whom molested and mistreated Jennifer. At age 11, Jennifer defended her mother against a particularly violent partner by hitting him over the head with a frypan. In response, her mother beat Jennifer. In her early teenage years, she was repeatedly sexually assaulted by an uncle. Jennifer told her mother about these attacks, but this angered her mother so much that she punished Jennifer by forcing her hands onto a hot stove, leading to permanent deformities.

Jennifer has an older sister whose father is different to Jennifer's. Her sister's father is non-Indigenous and, after he passed away, his family adopted Jennifer's sister because she resembled him and was "more white". Because of Jennifer's strong resemblance to her mother, her paternal grandparents were not interested in adopting her. Jennifer refers to that side of the

family as “posh.” Jennifer has had only one birthday in her community since she was 11, with all others in juvenile detention or prison.

Most connections with Jennifer are made via the prison psychologist who uses animal picture cards slipped under the door of the cell to initiate conversation. Jennifer loves animals, with the exception of German Shepherd dogs, which is the breed of dog used within the prison. In general, she will look at the cards for 20 minutes or so before starting to talk. One of the challenges for staff is the uniform they are required to wear. For Jennifer, the uniform closely resembles that worn by police and this creates a barrier that can be problematic. She fantasises about killing police officers.

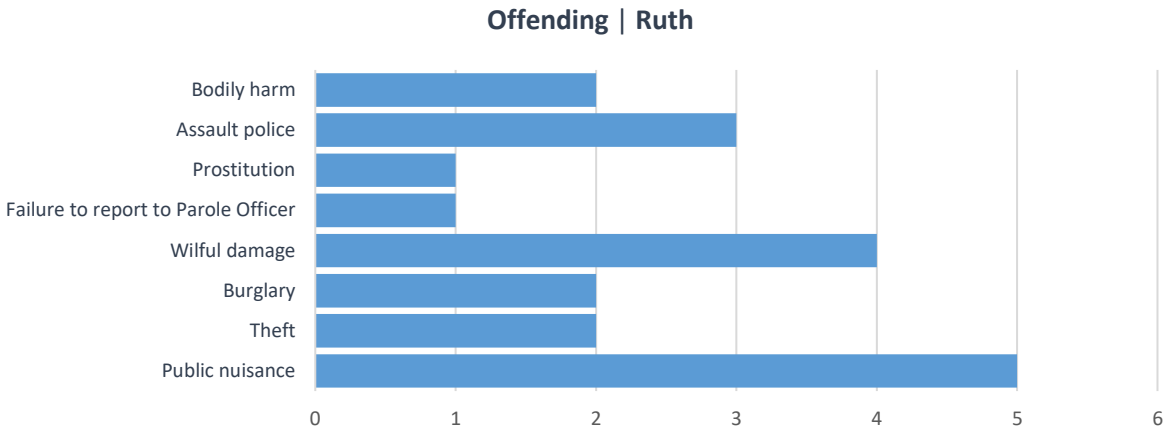
Jennifer is the victim of a betrayal of trust, particularly at the hands of her mother. Rejection by her paternal grandparents for being ‘too black’ and the separation from her sister have added to problems that now manifest themselves in overly violent and antisocial behaviour, further isolating her both physically and emotionally. Her aggressiveness within the prison environment results in much of her time being spent in the Secure Unit, isolated in a monitored cell. The cycle of self-harm and behaviour emanating from fear, distrust, anger and frustration makes it unlikely that Jennifer will be able to function in a manner that is safe to her and those around her while she remains in prison. Prison personnel believe that she will inevitably spend much of her life in prison.

Ruth (36, non-Indigenous)

Background: Ruth has lived in several states including New South Wales, Queensland and South Australia. She has an ABI due to an extensive history of substance abuse. Her criminal history began in 2008 with major property and public nuisance offences. She was granted parole but had this suspended as she failed to report to her parole officer. She was homeless, and so locating her was difficult. As part of her parole order, she had to report to a city branch office which involved a walk of around 10 kilometres each way. This was hard for her. With caseloads often extending to 50 or more clients, there were insufficient resources for parole officers to be able to follow up with Ruth.

Efforts were made to locate her through the Office of the Public Guardian, state mental health services, police, the hospital and the Diversionary Centre. As Ruth did not have a Guardianship Order, this office could provide little assistance. Ruth has drug-induced, psychotic-based mental health issues.

Ruth's offending history



Ruth's life: Ruth has been sexually abused. She is severely traumatised and believes that men are taking her possessions. She has been flagged for sex offending with allegations of prostitution, though no formal charges were laid. Ruth is violent towards the other prisoners but not towards the prison staff. She is also violent when in the community.

Ruth was pregnant at the time of interview and due to give birth in six weeks. The prison indicated that the baby would be taken straight into foster care. Ruth has a partner who regularly contacts the prison and abuses the staff. He is adamant about claiming the baby but has no interest in Ruth. Because of her pregnancy, Ruth's drug regime has been altered, which is problematic as her moods fluctuate significantly. She has also been diagnosed with schizophrenia. Her antisocial behaviour is linked to her ABI. She feels that there is no one she can trust while simultaneously believing that her pregnancy will 'protect' her while she is in prison. Ruth dislikes Indigenous people and can be violent towards them. This is difficult to manage in the prison environment. It is unclear what triggered this dislike.

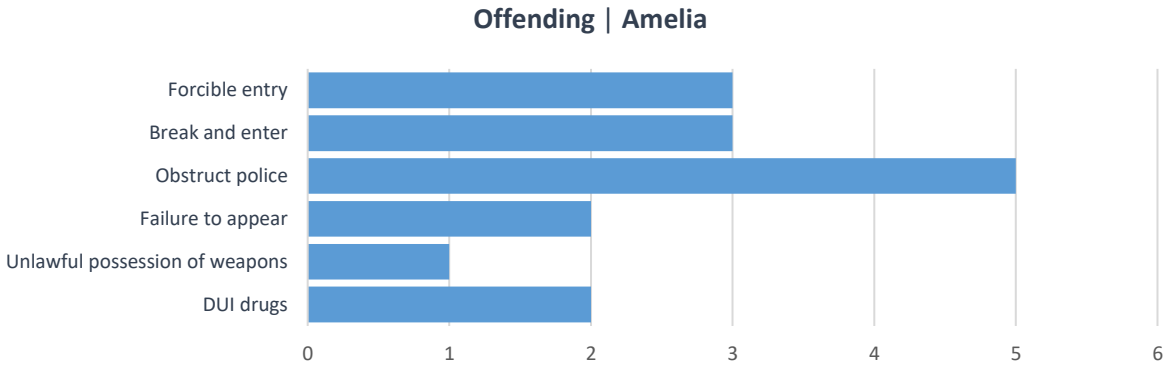
Ruth has no family or community support. Her life has included physical and sexual abuse, homelessness and incarceration. There is potential for Ruth to continue to cycle in and out of prison unless she receives appropriate assistance that urgently addresses drug addiction, accommodation and ongoing mental health issues.

Amelia (50, non-Indigenous)

Background: Amelia is in prison for drug possession, driving under the influence, weapons possession, break and enter, assault of police and failing to appear in court. At the time of interview, she was remanded in custody. Amelia was born with Fetal Alcohol Syndrome. Some of the facts about her history have not been verified and Amelia's own recollections were

confused and contradictory. For example, she spoke about her parents being in the army, making her feel as though "I've been in prison all my life." She said that her parents worked on a ship when she was young and that she was exposed to "all the fumes the engine made." However, she also said that she was mostly locked in her room where she slept most of the day. The psychologist believes that Amelia is incapable of looking after herself. While she is not psychotic, her moods are constantly elevated and she is housed in the Secure Unit on 30-minute observations. She has also been a patient in the prison's psychiatric facility. When speaking about her past, there was little cohesion to her narrative, and it has been problematic for prison staff to put together an accurate history.

Amelia's offending history



Amelia's life: Amelia was upset and crying throughout her interview, but was adamant about telling her story, repeating several times, "I just want my story told". While the narrative concerning her past revealed certain inconsistencies, there were several themes that dominated the conversation. She spoke about how she just wanted to be loved, needed and respected. She spoke about her carer (presumably different to her husband) and the fact that he took care of her and showed her respect. Amelia said that she was exempted from school but did not provide a reason or timeframe for this. She maintained she was badly bullied at school. She also said that her mother had been afflicted with early onset Alzheimer's and was not there for Amelia during her teenage and early adult years, but that her mother had done a lot for her when she was little. "Maybe she mothered me too much." Amelia then said that "I learnt stuff by watching other people's mothers".

Amelia has a husband and five children. She is listed as having several aliases. Drugs and alcohol have played a significant part in her life and much of her offending is related to this. Information provided by Amelia herself and from the psychologist revealed a history of physical and sexual abuse. She spoke about having her right arm and both her collarbones broken by her husband, pulling the shoulders of her top down several times to reveal the damage

and considerable deformities resulting from this. She also had her teeth smashed by a hammer, which she said occurred at the hands of her husband when he was affected by alcohol.

Amelia is bullied in prison. She wants to be transferred to Residential, a low-security facility in the prison, where the women work for the RSPCA looking after cats, caring for them and socialising them prior to adoption. (The psychologist said that this would be too overwhelming for Amelia and she would be unable to cope. Daily visits might be considered, but only if there was staff available to closely monitor this). Amelia once had a job working in a boarding kennel for dogs. She liked this and felt that the skills she learned would be helpful with the animals housed in the prison.

Amelia has never had visitors in prison, nor has she received any other forms of communication such as phone calls or letters. She writes letters to one of the prison's counsellors. She would like to write to her children but does not know where they are. She knows that they were taken into care by CPS but has little knowledge of them beyond this. Amelia's understanding of why she is in prison is limited, with constant reference to the fact that "I don't deserve to be here". She is keen to eventually be given home detention but unsure of what home she could go to for this to transpire. She constantly pleaded for someone to find a way to help her "get out of this place". Amelia is bewildered, frustrated and deeply sad.

Rachel (20, non-Indigenous)

Background: Rachel is complex young person with complex needs. She suffers from BPD and is a chronic self-harmer. She is in prison for serious arson offences and much of the counselling she receives is focused on these behaviours, as well as addressing aspects such as vulnerability associated with acquiescence. She likes the structure of prison, which she says makes her feel safe. Rachel's cognitive disability is a sensitive area for her. She does not like acknowledging it, although she is aware of its existence. Housing and accommodation have been problematic as Rachel refuses to live in specialist disability housing, feeling that she does not belong there.

Rachel has previously been given court-ordered parole, but this was revoked almost immediately because of her fire-starting behaviours. Her father has visited her in prison once or twice, but these visits have been confusing for Rachel and problematic for the prison because of his drug-related offending and criminal history. Rachel says she simultaneously "loves him and hates him". Rachel has never used drugs. She went to juvenile detention when she was 15 before being transferred to an adult facility at age 17. She is heavily scarred from self-harming. Prison staff believe that Rachel could be released within six months (from the time of

interview), but they cite appropriate accommodation as the problem preventing this from happening.

Rachel's life: Rachel's family is dysfunctional. She is one of five children. Her protective instincts are highly apparent when she speaks about her brothers and sisters. Each of the children has a different father. At the time of interview, Rachel had a new baby sister, born to a partner of her mother who Rachel is yet to meet. Her parents separated when Rachel was nine years old and she remained with her father. Rachel went to Year 9 at school and particularly liked playing different sports. She was not bullied at school and has not been bullied since coming to prison.

When talking about catalysts for offending behaviour, Rachel said, "Because dad did some stuff to me". She said that she also had an aunt her mistreated her. Rachel's mother has mental health issues and abused Rachel, her brothers and her sisters. When she was 15, Rachel went to live with her mother, but her mother's mental health problems worsened. Rachel escaped by running away. While in juvenile detention, she received visits from her grandparents, a great-grandmother and occasionally her father. She is very close to her grandparents and is happiest when she is with them, although they are unable to care for her when she exits prison as they are unwell. However, she speaks with them on the phone regularly, along with her siblings. She has never had a birthday visitor, although some of the family have said happy birthday to her on the phone. Her mother has never visited or attempted to contact her, and Rachel believes she never will. She has had no contact with any of the friends she had prior to coming to prison.

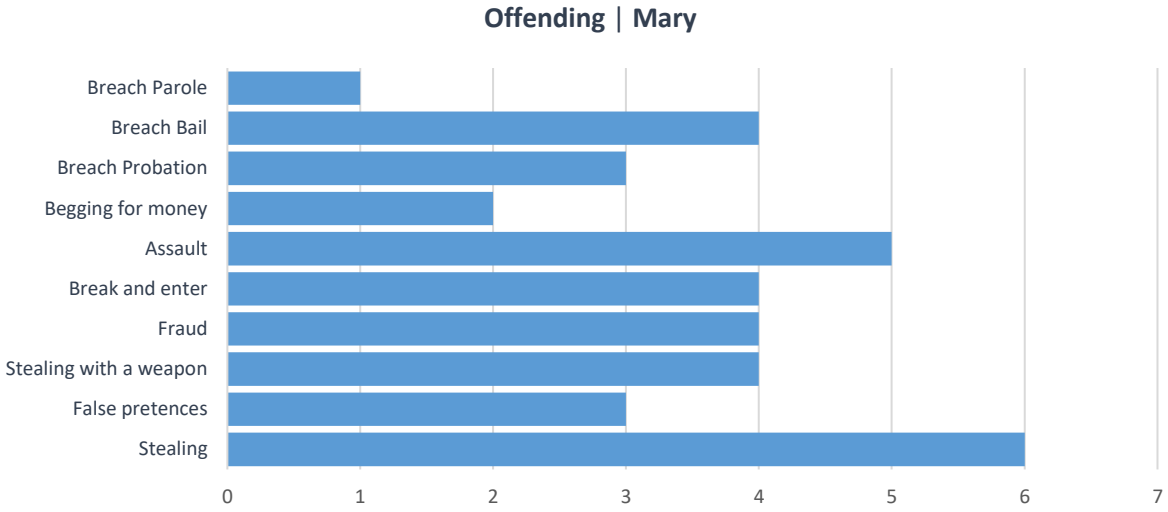
Rachel loves animals, especially dogs, and would like to work for the RSPCA. She feeds the pigeons her breakfast muesli. "I know that bread is really bad for them, but muesli looks like bird-seed, so I know it's alright for them". Rachel was happiest when talking about her grandparents and the fact that they had promised to come and collect her upon her release. She is adamant that she does not want children of her own. Despite a past marked by various forms of abuse and family dysfunction, Rachel is polite and respectful with a happy and optimistic demeanour.

Mary (44, non-Indigenous)

Background: Mary suffers from a mood disorder and her cognitive disability has been identified by Corrective Services via HASI. Mary has an extensive history of drug use, predominantly heroin, which she is unable to control when she is out of prison. She was addicted to both drugs and alcohol by the time she was 10, introduced to these substances by an older sister. She started using amphetamines at age 15. Her drug addiction was expensive and Mary resorted to stealing

to support it. Her cognitive disability is thought to be a consequence of prolonged drug and alcohol addiction. Mary has had eight custodial episodes, with some of her convictions related to stealing using a weapon, numerous charges of fraud (particularly associated with Centrelink payments) and begging for money. The prison psychologist credits grief and poor coping skills as partly responsible for Mary's offending.

Mary's offending history



Mary's life: When talking about her family life, Mary said it was "a nightmare". She did not get on with her siblings or her mother, who she disliked intensely. She has had no contact with any of them since she was 12. She had minimal contact with her father, who visited her in prison during her first custodial episode. Mary was very fond of him and extremely upset when he died in a freak accident when she was 31. Mary had her first baby when she was 12 years old and now has six children. She has had the same partner for 32 years. Because she left school in Year 6 to give birth, she is only semi-literate and struggles to read and write. She left home just after her twelfth birthday to take up residence with her child's father. She has never had a job outside of the home. She had two children at the time of her first incarceration. Mary was 22 and "terrified". She vividly recalls the strip search procedure and the face of the officer who conducted it. Between periods of imprisonment, Mary lives with her partner and five of their children, as well as two grandchildren (her oldest child's children). Her partner's mother taught her how to take care of her babies. Her partner does not use drugs or alcohol, which provides some stability to Mary.

Mary is relatively settled in the prison environment, although she suffers from bouts of depression, primarily due to a lack of contact with her children. She does not want them to see her in prison. Mary shares her prison accommodation with other women who were also

incarcerated at the time of her initial custodial episode. She finds this reassuring as she feels she knows them well and they are friends. She is in a low-security area with her own cell that has a television. She and the other women cook for themselves. She works for several hours a day in one of the prison workshops which is mandatory for women living in the low-security area. Refusing to work elicits a return to the Secure Unit. Mary has also completed a barista's course and obtained her forklift license while in prison.

At the time of interview, Mary's oldest child (aged 32) had only a short time to live as he was terminally ill with AIDS, contracted through sharing needles. Mary was upset because his drug addiction caused him to repeatedly discharge himself from hospital, resulting in an escalation of his addictive behaviours and further deterioration in his health. Mary receives updates from the younger children's schools about their progress, as well as school photos. Her youngest child is eight and was born in prison. He remained with Mary for six months before going to live with his father. With the exception of her oldest son, all her children write letters to her. She has participated in 'Storybook Mums', telling a story that is recorded and sent to her children.

Mary's main supports are her partner and oldest daughter, and she credits them with trying to help her stay 'clean' and crime-free. She receives counselling from the prison chaplain with whom she has a good relationship. Above all else, Mary wants to go home to her children. She acknowledges that each time she exits prison she vows she will not return, but her addiction has never been addressed in any substantive way when she is in the community. Mary herself recognises the sadness associated with only receiving help when she comes to prison.

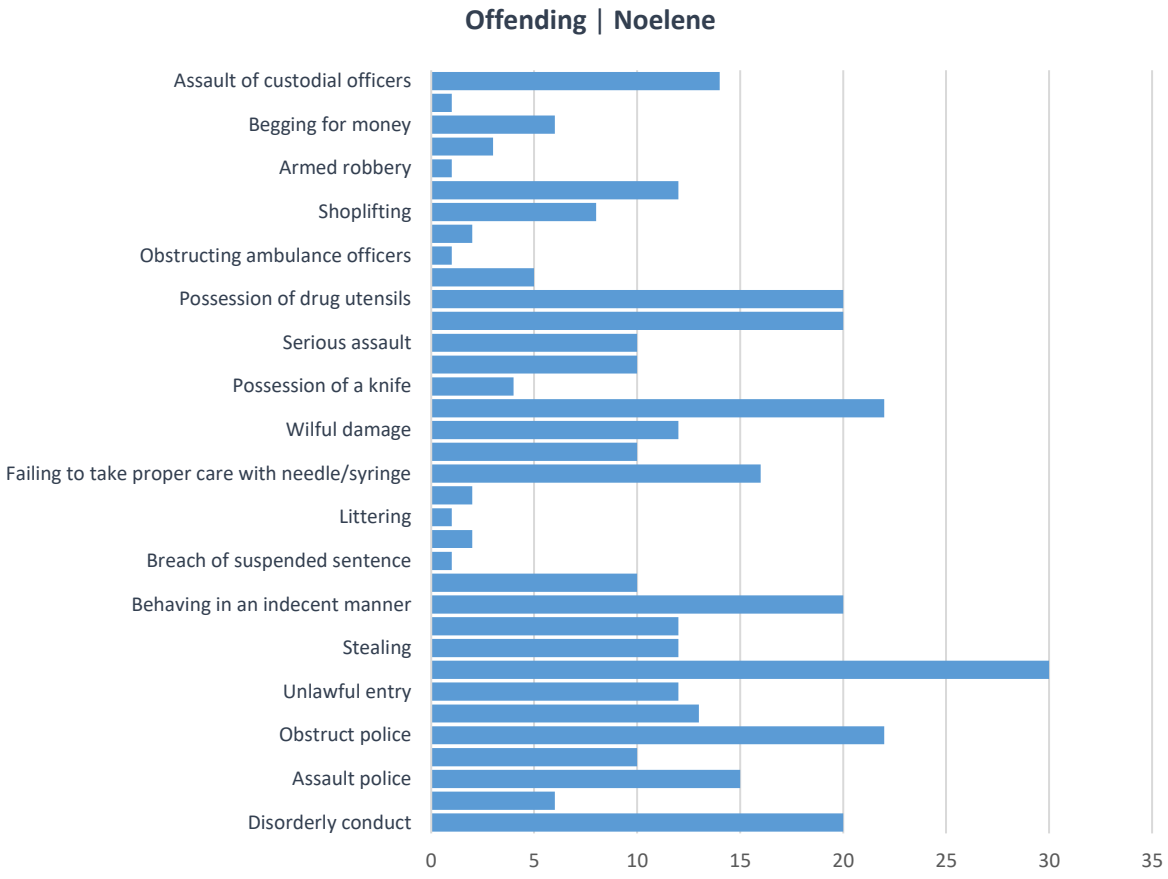
Noelene (37, Indigenous)

Background: Noelene has a mental age of approximately 12. She has BPD and an extensive history of drug use, which has further undermined her cognitive abilities. Alcohol has not been part of her addiction. Her short-term memory is compromised, making it difficult for her to retain new information. She is heavily scarred from the lacerations of self-harm. Her self-harming is chronic.

Noelene's criminal record began when she was 15. She was convicted of an array of crimes including serious assault, assault of a police officer, unlawful entry and stealing. She was placed in juvenile detention but continued offending after her release. As well as repeat instances of the crimes that saw her detained in a juvenile facility, she was also convicted of using a phone to threaten others, bodily harm, behaving in an indecent manner and multiple counts of assault and disorderly conduct. Her offending escalated to include possession of a knife, possession of

dangerous drugs, attempted armed robbery, numerous counts of wilful damage, prostitution, Centrelink fraud and further charges of serious assault. She was also cited for begging and failing to dispose of a needle properly. At the time of interview, she was in prison for stabbing a man. Her offending has continued while incarcerated, with several assault charges, primarily against prison officers, resulting in confinement in the Secure Unit. At the time of interview, Noelene was accommodated in the secure Mental Health Unit.

Noelene's offending history



Noelene's life: Noelene is Torres Strait Islander on her mother's side but knows very little about her Indigenous heritage, although she has had occasional visits from the prison Elders. Her siblings also have very limited knowledge of their cultural legacy. Noelene did not have a good relationship with her mother and stepfather, nor with her siblings. She never knew her biological father. An older brother has since reconnected with Noelene and she sometimes talks to him and his children on the phone. He has also visited Noelene in prison. Noelene also talks to friends on the phone. Her friends are people she has met in prison who have been released. She wants to meet up with them when she is released.

She attended a state school spasmodically until Year 9, which she enjoyed, especially the art classes. She was then transferred to a special school where she was extremely unhappy as she was constantly bullied. Her happiest memory of this time was learning to swim which she was very good at. During this time, Noelene was placed in foster care, as were her siblings, although they were not all placed in the same foster home. This initiated a succession of foster homes for Noelene. She was desperately unhappy in all of them. “If they got sick of me, they just moved me on”. She had no friends and was not allowed to have anyone come over to play.

Noelene spends much of her time in solitary confinement. She can be violent at times, and her solitary confinement is a disciplinary measure. When she strikes out, it is always unexpected with no visual or verbal clues or elevated mood indicating that it is about to happen. She is continually hitting the prison staff. Her propensity for self-harm means that Noelene is mostly confined to fully monitored cells under 15-minute observations. Self-harm occurs via objects as small as a paint chip.

Noelene is eager to access substance abuse counselling before she leaves prison. Literacy and numeracy are important to her and some of the officers help her with maths and spelling. Noelene has good and bad days. On several occasions, she has come close to being able to leave the Secure Unit, but self-sabotages with statements such as “I want to die”. The psychologist noted that a distinct pattern has emerged. As Noelene gets closer to a release date, she realises she will be exiting prison and her future is uncertain. She assaults one of the prison staff which ensures she will remain in custody. Noelene’s past causes her much unhappiness and she thinks about it a great deal. She has happy memories of visiting a hilltop lookout with her brother a few years ago. The psychologist has taught her visualisation skills and Noelene pictures herself at the lookout as a way of coping with the present.

Alice (25, Indigenous)

Background: Alice is accommodated in the prison’s Secure Unit and is on 15-minute observations. At the time of interview, she was serving her third custodial sentence. Her crimes are predominantly drug-related (e.g., possession and possession of drug utensils). She has a significant substance misuse disorder (including alcohol) and smoked cannabis from a very young age. She is a chronic self-harmer and heavily scarred. Prior to prison, Alice maintained ties to her community. However, during the times she is incarcerated her parents do not visit and only the adult guardian occasionally sees her.

Alice's offending history

Alice's life: Alice lived with her mother until she was 11, moving to live with her father from ages 11–13. She was then given over to state care where she was mostly cared for by a youth worker. She was transferred to foster parents but ran away after less than a week. She repeated this several times as she wanted to go back to her father. It is unclear why he was unable to care for her. Alice was in state care for seven years. Alice's mother remarried and Alice loves her stepfather. He and her mother now have another young child who Alice is very fond of. She has only seen her biological father twice since she was 17. She has six siblings: one biological sister and five half-brothers and sisters who have different fathers. She is closest to her mother and stepfather's child. She speaks to her siblings on the phone, as well as to her mother and stepfather.

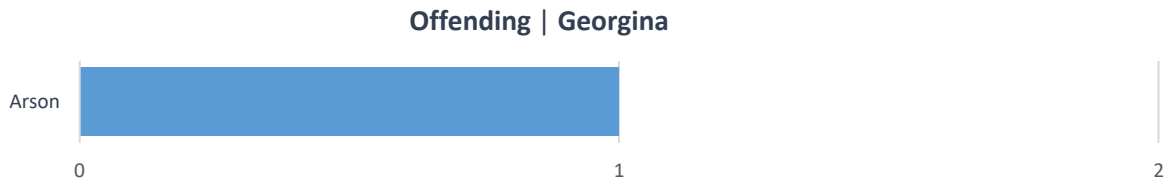
Alice went to Year 10 but hated school. She did not participate in any sporting or school activities. While at school, she did work experience with McDonald's and Meals on Wheels, both of which she enjoyed because she received free food. She lived with her partner before entering prison. She had a child who died shortly after she was incarcerated. The child was six years old and in the custody of Alice's aunt. Alice was unclear as to the circumstances of the death. Her partner has four children from a previous relationship, but they do not live with him as he is a drug user. He has had no contact with Alice since she has been in prison.

Alice's older (biological) sister had twins who were born prematurely. The little girl died and the little boy was still in the Intensive Care Unit at the time of interview. Shortly before this, Alice's younger brother attempted suicide on his fourteenth birthday. Alice cited the fact that he had lost eight people in under two years. She also said that the loss of family members was the main catalyst for her acts of self-harm, which she attempts most days. Alice has been deeply affected by the loss of life in her family and also by the years spent in foster care.

Georgina (18, non-Indigenous)

Background: Georgina is accommodated in the prison's Secure Unit, charged with serious arson offences. She is a chronic self-harmer and her legs, arms and neck are deeply scarred. Her father was in the military and lost both his legs in combat. During her interview, Georgina said that one of the things that would make her happy is paying her 'friend' to cut her leg off. The psychologist believes that Georgina witnessed the intensive care her father received and continues to receive because of his injuries. Georgina's mother has BPD which has been unsettling for Georgina. Georgina drinks alcohol and has also used drugs, but her drug use is intermittent as she said they are too expensive.

Georgina's offending history



Georgina's life: Georgina's school life was punctuated by several interstate moves. She hated school and said that she was badly bullied. While the teachers were aware of this, they did little to help. She had specialist teachers to help her with her speech which is marred by an impediment causing her words to be quite slurred. Georgina played water polo for one of her schools. This was the only activity outside of the self-harm narrative about which she expressed pleasure.

Georgina was sexually assaulted by her maternal grandfather. However, when she attempted to talk to her mother about it, her mother accused Georgina of lying, saying that such a thing was not possible. After this, Georgina gradually became more violent and unpredictable. Her parents felt that they could no longer have her in the house because she presented a danger to her younger siblings and her twin brother. They surrendered her to CPS in whose care she remained until she turned 18 and aged out of the system. Georgina was placed in a substantial number of different homes and was sexually abused in several of them. She reacted by punching holes in the walls of her room. She also hit the carers because, "they were getting away with things". She attempted to tell CPS, but they did not help her. Georgina said, "They just didn't care". She now has an adult guardian.

Georgina expressed no emotional connection with either her parents or her siblings, including her twin. When speaking about pets the family has owned, she said she had no feelings for them

and cared little if they lived or died. She has no friends and has not communicated with anybody other than prison staff since coming to prison.

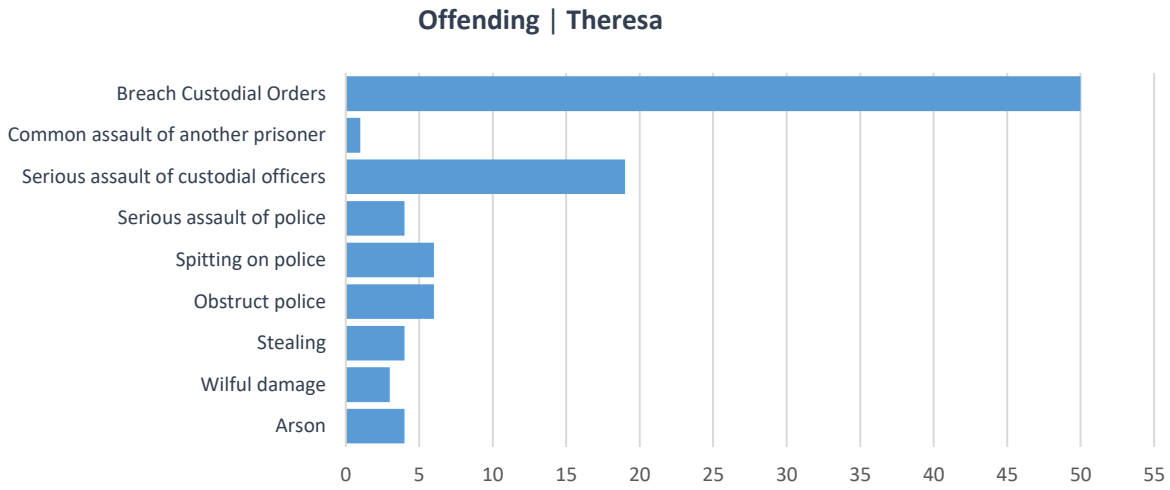
Georgina met an older man on the streets who took her to his house. She said that this 'friend' makes her feel happy as he hurts her physically and sexually: "I knew that if I went to his house, he'd hurt me. He's the only one I know who can really hurt me. It doesn't matter if he likes me or not—I asked him to do it". Georgina is angry a great deal of the time. Much of this is directed at the custodial officers because they do not let her harm herself. She said, "I enjoy hurting myself". When speaking about things that make her happy, Georgina said, "I hate myself. That makes me happy".

Following her interview, Georgina was hostile towards the officers who accompanied her back to her cell. This stemmed from the fact that she had been diverted throughout the interview from talking about the ways in which she wanted to harm herself, wanting to use this time as an opportunity to expand on this in more detail. Georgina's parents and siblings have never visited her in prison. She does not want her 'friend' to come to prison to see her but is eager to reconnect with him when she leaves prison.

Theresa (44, Indigenous and Torres Strait Islander)

Theresa has a genetic disorder, a chromosomal abnormality, which she was able to explain. Her daughter has inherited the same abnormality, as did her son who died in utero at 20 weeks. She suffers from kleptomania, depression and anxiety and is a recovering bulimic. Theresa has been in prison nine times with charges still pending for damaging the camera in her cell, assaulting a custodial officer and assaulting another prisoner. She has had over 30 custodial breaches in less than a year, resulting in her confinement in the Detention Unit with little chance of moving to a low-security facility. She is in prison for numerous counts of arson, wilful damage, stealing and assault of police, with her sentence extended for a number of assaults on custodial officers. Theresa came to her interview with a severe bruise and semi-open wound over her right eye, caused by a custodial officer against whom Theresa is pressing charges.

Theresa's offending history



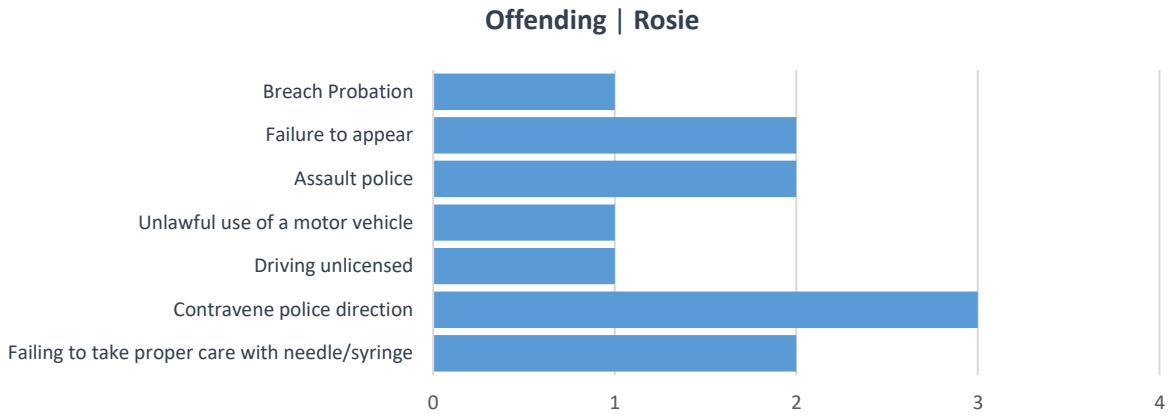
Theresa's life: Theresa lived with both her parents when she was little. She had a younger brother who died when he was six months old as the result of a car accident. Theresa was three at the time and also involved in the accident. Theresa attended her local school and enjoyed English and Home Economics. She went to Year 8 and then did Years 8–10 via correspondence. She was bullied at school for being overweight, which foreshadowed the onset of bulimia. She has had several part-time jobs such as pamphlet delivery and food preparation in a hotel. She has not had a job for a long time and feels nervous about trying to apply for one when she exits prison.

At the time of interview, several of Theresa's family members were also incarcerated. She has a partner who is 33 years older than her. Theresa met her partner through his daughter who was incarcerated at the same time as Theresa. She also has half-brothers and sisters. She maintains contact with the Elders. She has visitors quite regularly. Her partner comes to see her every week and her half-siblings have also been to visit. However, she has not seen her teenage daughter for over four years and says they are estranged. Her daughter is in the care of CPS who maintain communication with Theresa. She does not want to leave the Detention Unit because she feels safe there.

Rosie (26, Indigenous)

Background: Rosie is accommodated in the prison's Secure Unit. Her cognitive disability was identified and assessed during her primary school years. Drugs and alcohol have always been in Rosie's life. Little is known about her father, but her mother has chronic substance abuse problems, as does her brother. Early drug and alcohol use contributed to Rosie's cognitive disability.

Rosie's offending history



Rosie's life: Rosie's grandmother has been her primary carer. She calls her grandmother 'Mum'. Her biological mother has been in and out of her life and although Rosie wanted to live with her, her mother did not want this as she was caring for Rosie's younger siblings and felt that she could not cope with three children. This continues to cause Rosie much sadness. Rosie's siblings were eventually taken by CPS because their mother was in and out of prison, predominantly for drug use. Upon exiting prison, her mother fought to regain custody of Rosie's siblings, but not Rosie herself. Rosie struggled with intense jealousy because of this.

When Rosie was young, her mother often hit her. Now that Rosie is an adult, she and her mother do not interact well. According to Rosie, both her mother and brother 'goad' her and can be very nasty. In response, Rosie has visited their house, smashed windows and caused other damage. Her mother and brother are addicted to ice and heroin. Because of this, Rosie was anti-drugs but was curious about ice and began using. This marked the beginning of depression for which Rosie did not seek help, instead choosing to self-medicate. The ice exacerbated her depression, setting up a destructive cycle. Rosie's sister is also an ice and heroin addict. She has two children and, at the time of Rosie's interview, was pregnant with her third child. She continued drug use during her pregnancies and her second child was an 'ice baby', suffering through withdrawal from the time of birth. Rosie's sister's partner was serving a four-year sentence at the time of interview.

Rosie hated school and was expelled from her local state school on charges of arson. She did not participate in any sport at school or any community activities. During her teenage years, she attended a special school and was happy there.

Rosie has a seven-year-old child who, along with her sister's children, is cared for by Rosie's grandmother. Initially, her child was forcibly removed by CPS following an incident in which

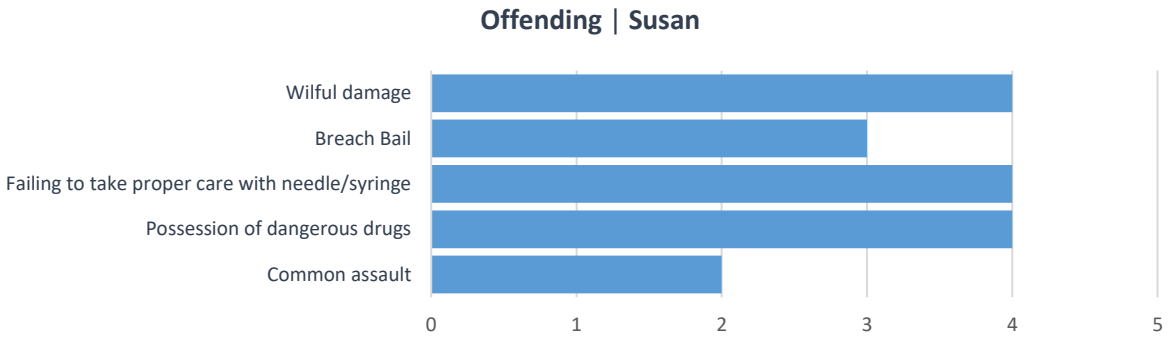
the child was reported to them by a doctor because she had untreated and infected wounds on her arms. Rosie speaks with her daughter once a week on the phone. She does not want her child to see her in prison and has had no other contact with her child during her incarceration. She has received no visitors in prison, although her grandmother sends her money. Rosie believes that she is unlikely to regain custody of her child when she leaves prison because of her addiction to ice, which has halted since her incarceration. She no longer has contact with her child's father, who, according to Rosie, wanted her to have a termination. He has had nothing to do with their child and has never seen her. He has served time in prison for domestic violence against Rosie.

Rosie feels sad all the time. She misses her grandmother and daughter and is upset by the prospect of not being allowed to regain custody of her child. She has no friends, although she likes several of the women she has met in prison. She believes that prison has been a "wake-up call" for her and wants to improve her life when she is released.

Susan (30, Indigenous)

Background: Susan has had two custodial episodes, with charges relating to drug possession, failure to dispose of needles properly, wilful damage and assault. She is addicted to heroin. Susan attended up to Year 9. Her cognitive disability was identified during her primary school years. She is accommodated in the Safety Unit as she has talked about harming herself, claiming she heard a man's voice telling her to hit herself. Although she was in the low-security unit for a short time, she was bullied by the other women and was transferred to the high-security wing for her own safety.

Susan's offending history



Susan's life: Susan's upbringing was quite different to that of the other women. She lived in Syria for 18 months as her stepfather worked for the United Nations. She went to school there but disliked living in Syria. Her younger siblings also lived there. After their return to Australia

when Susan was 15, she lived with her grandfather. Her stepfather took her there on instructions from Susan's mother. Her mother now lives in Europe and Susan has not seen her for many years. Susan was upset when she described how her mother often told her that she loved Susan's siblings more than Susan. She believes that this was the catalyst for her drug use and why she has been angry for most of her life. Susan was diagnosed with attention-deficit hyperactivity disorder (ADHD) as a child and was prescribed medication which her mother refused to buy. She was told that if she did not take the medication, her ADHD would manifest as BD in her adult years. Susan has been diagnosed with BD and the prison has issued her with medication for this.

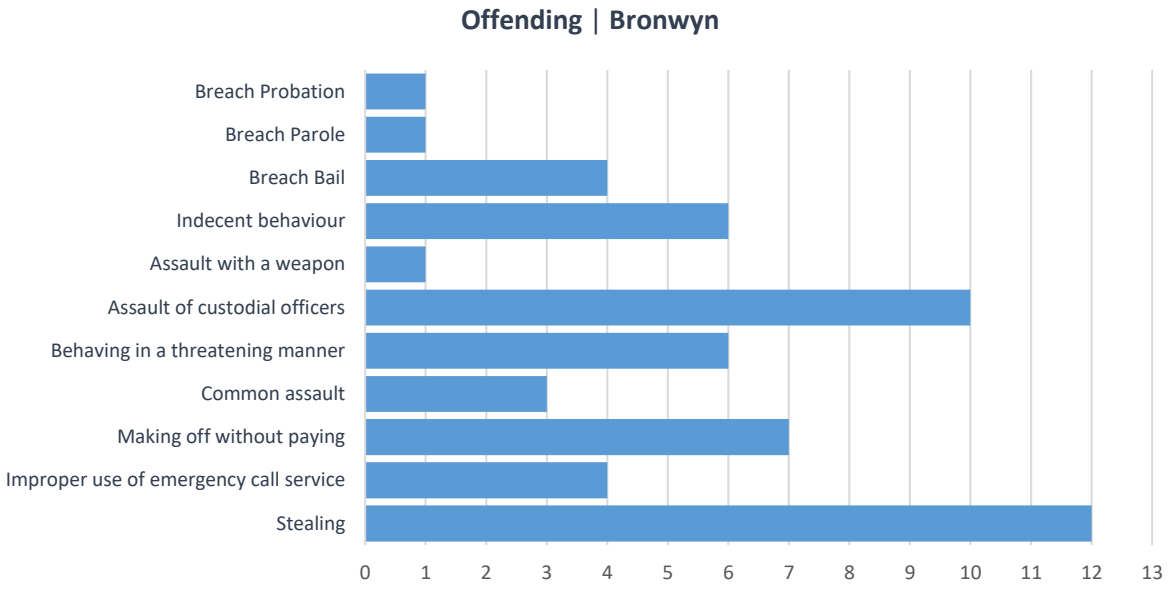
From the age of 16, Susan was predominantly homeless. At times she slept in a park or as close to a police station as possible. She always tried to find somewhere that was well lit, believing it to be safer. She was pregnant during her times on the street, asking strangers to call for medical help when she went into labour. CPS removed the children within days of their births. Susan has had no contact with CPS. She has five children (aged 11, nine, seven, six and four) who she has not seen for over three years. She also had a baby who was stillborn. Her sons are in one foster home and her daughters in another. She does not talk to them on the phone. At the time of interview, her partner had been released from prison after serving a two-year sentence. Despite promising to help Susan financially this has not happened, in part due to his own incarceration. Susan hates being in prison. However, she acknowledged that prison has been an opportunity to stop using.

Susan's community is in New South Wales and her cultural heritage is extremely important to her. She has seen the Elders several times since she has been in prison. Susan's immediate goals are to remain drug free and do an anger management course.

Bronwyn (25, non-Indigenous)

Background: Bronwyn is very low functioning. She has had 25 custodial episodes over a five-year period, mostly of quite short duration (i.e., less than three months). However, at the time of interview, she was awaiting sentencing for more serious crimes with the expectation that the sentence would be a minimum of six months. Being remanded in custody is very stressful for her as she has does not understand the court processes. In general, her charges relate to assault, stealing, 000 hoax calls, arson and behaving in a violent manner. Her offending occurs when she is intoxicated. She is not a drug user. She is a chronic self-harmer and so much of her time is spent in isolation in the secure wing. Bronwyn suffers from depression but is not on any medication. She is supported by the prison psychologists.

Bronwyn's offending history



Bronwyn's life: Bronwyn went to Year 10, with most of her education taking place in the 'high and additional needs' unit, which mostly focused on developing life skills. She had a difficult upbringing. She has seven siblings, three of whom also have cognitive disabilities. Bronwyn is the youngest in her family. Her mother is in a nursing home as the result of a brain aneurysm and her father, who is in his mid-seventies and a recovering alcoholic, struggles to care for Bronwyn and another severely intellectually disabled daughter. Several of Bronwyn's siblings are drug users and it upsets Bronwyn when they use drugs in front of their children. Bronwyn was raped by a man known to her family when she was 14. It was after this that she started to drink heavily and attract police attention. Many of her charges, both historic and current, are for assaulting police. She becomes extremely distressed when intoxicated, lashing out randomly.

When not incarcerated, Bronwyn lives with her father, who collects cans and other disposables which he takes to the scrap metal yard to earn money. Bronwyn previously had a part-time job as a dog groomer, but the frequent nature of her incarceration means that it is problematic to obtain and keep a job. While she has done TAFE Certificates in aged care and childcare, neither of these are options for employment because of her criminal record.

When she is not in prison, Bronwyn drinks heavily, which exacerbates her feelings of anger and her depression. She can feel the changes happening and promises herself that she will not drink again, but this resolve is always short-lived. The people she associates with encourage her to drink which also contributes to patterns of alcohol consumption. Bronwyn's vulnerability extends beyond the prison. She maintains that when she is sober she is unable to 'stick up for

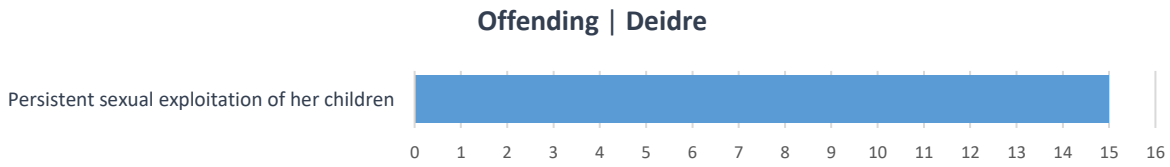
herself', but when she drinks she feels more courageous. However, it is at these times she becomes aggressive, which attracts police attention and the cycle begins again.

Deidre (34, non-Indigenous)

Deidre's life experiences appear in greater detail in Appendix 7. This is a brief summary.

Deidre has an assessed IQ of 55. Prior to her incarceration, she had a chronic substance abuse problem, especially for heroin and alcohol. She had a severe eating disorder and suffered from depression. This was Deidre's only custodial episode and her first interaction with the CJS. She was imprisoned for the sexual exploitation of her four children. At the time of interview, she had been granted parole and was moving to supported accommodation.

Deidre's offending history



Deidre's life: Deidre grew up in a very violent household, neglected, abused both physically and verbally, and sexually abused by her grandfather. She despised her mother who was alcoholic, schizophrenic, bipolar and suffered from depression. Deidre was often placed in either respite care or a group home during times when her mother was alcohol affected or depressed. She loved her father, who left the family when Deidre was 12. She went to live with him for two years. She was devastated when he passed away, saying she had lost her 'best friend'. In contrast, she hated her mother and refused to attend her funeral in 2008.

Deidre's school life was spasmodic and mostly unhappy. She was illiterate when she came to prison. Deidre moved out of her father's home at age 15 and was quickly picked up by a man 10 years her senior (Murray) who promised to look after her. However, his drug use escalated and he became physically and sexually violent towards Deidre. They had four children, and Murray was physically and sexually violent towards them. Deidre was forcibly injected with heroin, ultimately becoming drug addicted. She also consumed large quantities of alcohol. Murray coerced her to take part in the sexual abuse of the children, threatening to kill them if she refused. He isolated Deidre from all contact with her family.

Upon coming to prison, Deidre also had to come off drugs and alcohol which was very difficult for her and increased her paranoia about everything inside the prison. It took almost two years

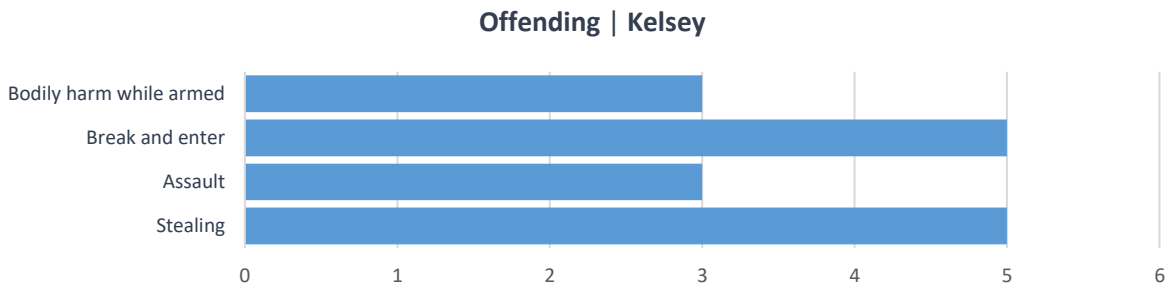
for the cravings to subside. Deidre's children were taken into foster care and Deidre was relieved that they all went to one foster mother who has continued to care for them. Deidre refers to her as "the best carer in the world". Murray's parents have made several unsuccessful attempts to gain custody of the children, although they are permitted to visit with them once a fortnight.

Deidre will never have contact with her children again. She is sad about this, but reassured by the fact that they are living in a stable environment. Once paroled, she plans to reconnect with her sister, brother-in-law and their children who have said they will support her.

Kelsey (21, Indigenous)

Kelsey's IQ is approximately 55. Kelsey has been remanded in custody nine times and, at the time of interview, was serving her second custodial sentence for stealing and assault. She is in medium security with her own cell. The psychologist notes that although Kelsey has been given bail, there have been no supports in place to help prevent her reoffending.

Kelsey's offending history



Kelsey's life: Kelsey's family life was chaotic. She was unclear as to the number of siblings as both her parents have had several relationships. She said there are "nine to twelve kids" ranging in age from 27 to four. She did not attend school, having been expelled at a young age for violence against staff and students. Kelsey expressed pride at her early expulsion from school. She was only 12 years old when she was raped by her father's best friend. "That's why my dad's in gaol. He killed him". Her father is currently serving a 25-year sentence for murder.

Kelsey was 'taken under the wing' of a neighbouring family who were heavily involved in various forms of crime. She became involved in crime, including stealing and assault. Kelsey's mother died when Kelsey was 16. Despite the crimes she was involved in, Kelsey felt she had to 'step up' for her four-year-old twin sisters and to ensure they had food and also went to bed.

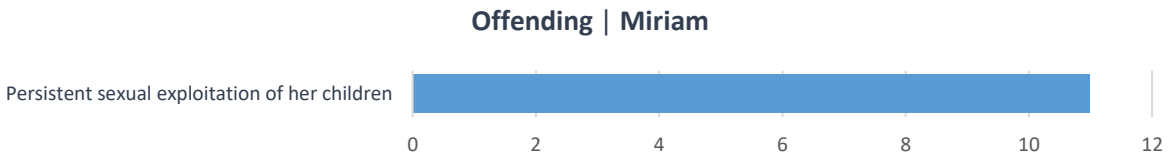
Kelsey has been with her current (much older) partner for seven years. He lives interstate and only infrequently contacts Kelsey, with no contact since she has been in prison. Her previous relationship lasted four years, which, according to Kelsey, is indicative of her loyalty. Kelsey talked about her hatred of paedophiles. She said, "They do that stuff to fucking kids. It makes me sick".

Kelsey plays volleyball with the other women from her unit. She has no desire to do any programs while in prison, although she completed a short maths course which she said helped her. Upon leaving prison, she said that she wants to volunteer with older people or children. She seemed unaware that neither of these options would be possible due to her criminal record.

Miriam (68, non-Indigenous)

Background: Miriam is serving a 12-year sentence for the persistent sexual exploitation of her three children. There was no male perpetrator involved. She is housed in the Protection Unit of the prison because of the nature of her crimes. She was sentenced retrospectively. According to Miriam, she turned herself into police after confiding in friends about her criminal acts. Miriam's cognitive disability was noted by the prison, although she was not formally tested. However, she attended a special school, indicating that her reduced intellectual functioning was identified by teachers and may have been tested at that stage.

Miriam's offending history



Miriam's life: Miriam's father worked with the railways and so the family moved around to various outback towns when Miriam was little. She is one of 12 children, although two of the children belonged to her father prior to his relationship with Miriam's mother. She attended high school for 12 months but said "I didn't learn nothin' there". She hated school and maintains that most of what she knows was self-taught. She was involved in "an incident" at school, although she did not disclose what this was, and was asked to leave.

Miriam married and had three children. She separated from her husband and retained full custody of the children. It was during this time that the sexual abuse of her children took place. Miriam now has a partner who has been in her life for 20 years. He has not met her children, and the children have not seen Miriam for over 30 years.

Miriam has mostly been employed as a cleaner and has rarely been without a job. Since her incarceration, she has completed a barista's course and attended literacy classes. At one stage she had a job as a prison cleaner, but not anymore. She did not expand on why this is the case. She said that she "gets treated like shit" by the other women prisoners and also the officers. She hates the routine in the Protection Unit and the boredom of being locked in a cell for 19 hours a day, with only five hours out of the cell. She commented, "I have to maintain a sense of humour, but you're bleeding inside". She tries not to express unhappiness in front of the officers as they may assume she is going to self-harm and transfer her to the Detention Unit, which she is frightened about.

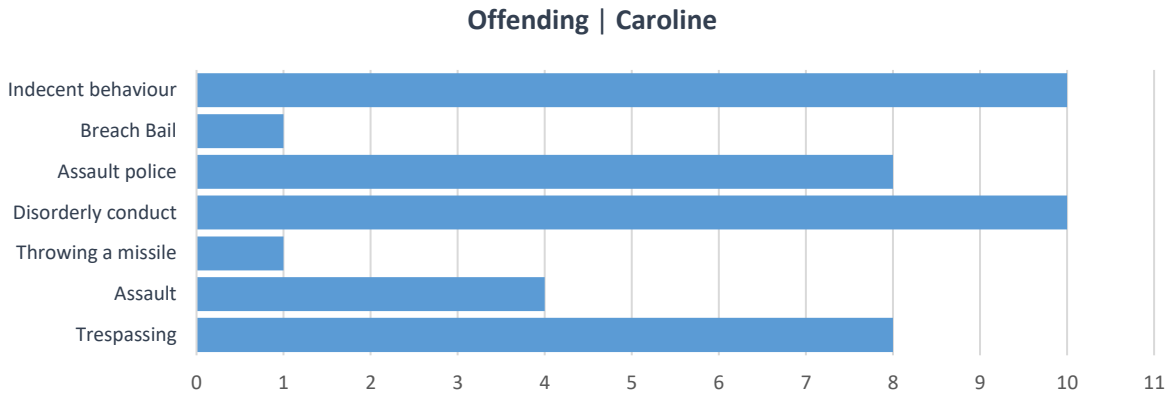
Miriam presents as a jovial person but is deeply unhappy. She will be quite old by the time she completes her sentence and is apprehensive about what her life will be like when she eventually steps outside the prison.

Caroline (31, Indigenous)

Caroline has cycled in and out of prison. She was first incarcerated in 2005 but received bail almost immediately, which she breached. Her second custodial episode followed in 2006 and, at the time of interview, was serving her tenth custodial sentence. Her crimes relate to trespass, assault of civilians and police, breach of bail conditions and indecent behaviour. She has previously been committed to a secure hospital to address her mental health issues She is under an administrative order from the Public Trustee.

Caroline is addicted to drugs and alcohol. Her substance abuse began at age 15 when she became addicted to Valium and methamphetamines, administering the latter via injections. She also drank a 50 ml bottle of spirits every day. She suffers from chronic depression and her extensive drug and alcohol history have significantly impacted her cognitive function. She has extremely limited adaptive skills and is highly vulnerable to acquiescence both in and out of prison. At the time of interview, she had been prescribed high doses of sedating medication. Caroline receives some limited help through mental health services, particularly with respect to housing options. Despite Caroline's cognitive disabilities, she has been rejected as an NDIS client, which prison counsellors said was "unbelievable". Additionally, she was deemed fit to stand trial, which was concerning to prison personnel given her inability to make rational choices and decisions or understand legal processes.

Caroline's offending history



Caroline's life: Caroline is the oldest of four sisters. Their grandmother took care of them when they were little. Caroline spasmodically attended a local school, where she was verbally bullied. Her sisters were protective of her and ensured that the bullying was not physical. Caroline wants to be with them when she exits prison. She occasionally met up with her mother outside of prison and has a friendly relationship with her. However, her mother is also addicted to drugs and alcohol. She has not seen her father for several years and he is listed in prison records as 'unknown'. She speaks to her grandmother on the phone and also an aunt. Caroline is supported in prison by another aunt who is the ALO and continues to advocate strongly for Caroline to receive supported accommodation. She also has a social worker assigned to her.

While living with her grandmother, Caroline was exposed to both drugs and alcohol. The house contains asbestos and is in a serious state of disrepair. There is drug paraphernalia throughout which belongs to Caroline's grandmother and others who are more transient.

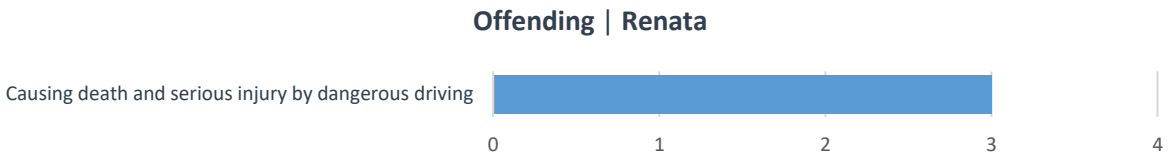
Caroline has two children. One child is a result of a sexual encounter in exchange for drugs, and the other a result of Caroline being raped. The children are with an aunt of Caroline's. The prison ALO has attempted on several occasions to ask Caroline's mother for help with the children because the aunt is struggling to cope. All approaches have thus far been unsuccessful, resulting in hostile reactions from Caroline's mother with the clear message that she has no interest in assisting with her grandchildren. The ALO believes that Caroline's cultural heritage will assume greater prominence in her life and encourages her to see this, rather than drugs and alcohol, as the way forward.

Renata (26, non-Indigenous)

Background: Renata has an ABI. She is serving a sentence for vehicular manslaughter in which a passenger in the car she was driving was killed. Renata was under the influence of cannabis

at the time and failed to stop at a stop sign. A second passenger sustained multiple serious injuries. Renata's ABI is a result of the accident. Her mother has power of attorney. Renata's history is different to the majority of the study's participants. She attended school until Year 12 with good results. She was bullied at school, which she found difficult to cope with. She had a variety of part-time jobs while still at school, working in cafes and clothing stores. Upon leaving school, she completed a TAFE Certificate 3 in Aged Care. At the time of the accident, she was a charity worker.

Renata's offending history



Renata's life: Renata is aware that her history and family circumstances are generally different to many of the women who end up in prison. Her parents purchased an acreage so that Renata could pursue her love of horses. She attended pony club and participated in dance classes. At age 16, her father passed away from multiple brain tumours and this was deeply distressing for Renata as she was very close to him. Her mother remains on the property and has remarried.

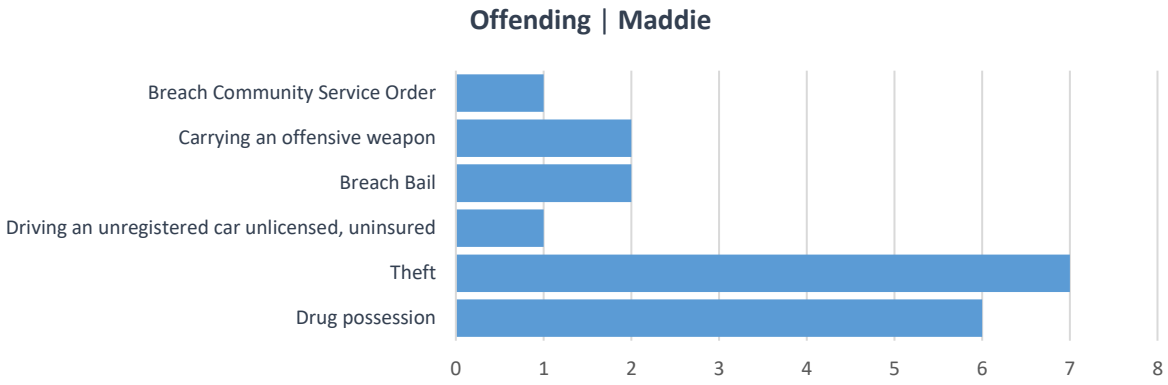
Renata had a baby three weeks after coming to prison. The child is in the care of Renata's mother. Because of the impending birth, Renata's lawyer advocated for home detention as the sentencing option, but this was denied by the court because of the loss of life. Renata's partner is not permitted to have custody of the child because of an extensive history of drug use. Renata's mother brings the baby to visit Renata every day for two hours. Renata keeps several photos of her baby in her cell. Her partner is not permitted to visit because of his known drug use. Renata gets on well with her partner's parents, although this relationship causes tension between Renata and her mother.

Renata is employed in the prison's kitchen, working from 7.30–11.30 am and again from 1.15–3.30 pm six days per week. She is accommodated in the Living Skills Unit, a low-security facility that acts as a conduit to the Pre-Release Centre. Renata goes to the prison gym and also the library where she enjoys reading. She receives mail from friends. Her mother, sister, partner and partner's parents all put money into her account so that she is able to purchase items she needs each week from the prison canteen. Renata hates being in prison, mostly because of the separation from her baby. She said, "I just do as I'm told. I don't want a reason to get into trouble".

Maddie (25, non-Indigenous)

Background: Maddie has been caught up in the CJS since 2009 and, at the time of interview, was serving her seventh custodial sentence. Charges include drug possession, theft (multiple charges), driving a car unlicensed, unregistered and uninsured, violation of bail conditions, carrying a weapon, assault and breach of a community service order. Maddie has dyslexia. She is illiterate and was a client of the state's Disability Services (prior to the NDIS) because of her ID. Although she is registered with the NDIS, this has little meaning in prison. Maddie has an older sister who tries to look out for her.

Maddie's offending history



Maddie's life: Maddie had a very unstable upbringing and left school at age 14. Her drug and alcohol abuse commenced around the age of 11. Her parents are both heavy substance abusers. At the time of interview, her father was also in custody and has an intervention order against him for domestic violence. He also cycles in and out of prison. Maddie's ID was identified at school. However, her early exit from formal schooling meant that little was done to assist her to develop cognitive ability or adaptive skills.

Maddie has three children. The first child was born when Maddie was 14. Her second child was born in custody. Shortly before her interview, Maddie gave birth to her third child, also born in custody. All three children are cared for by Maddie's grandmother. Maddie suffers from mental health disorders for which she receives medication in prison. She has been bullied physically and verbally, with verbal bullying directed towards her ID. She receives no visitors. Her grandmother is unable to bring Maddie's children to the prison as she has no formal identification. Maddie receives occasional phone calls from her sister and grandmother, but has had no communication with either of her parents. According to prison personnel, Maddie had no understanding of legal and court processes and finds prison confusing. She does not do any programs and the likelihood of her reoffending is high.

Appendix 6: Bronwyn's story

This is Bronwyn's story of going to court to apply for bail. Bronwyn appeared before the Magistrates' Court, charged with an array of offences. She had her lawyer with her, who argued in a convincing manner on Bronwyn's behalf. During Bronwyn's time on remand in prison, a non-government agency had obtained supported accommodation for her in a house relatively close to her father's home. This type of accommodation is difficult to secure and so this was quite a stroke of luck. Should Bronwyn receive a custodial sentence, then this opportunity would immediately evaporate. The lawyer spoke convincingly on Bronwyn's behalf, outlining the benefits of the accommodation, including the proximity to her father's house and the fact that it would be difficult to replicate this situation should Bronwyn go to prison. The magistrate, who certainly was not dismissive of the charges against Bronwyn, took an enlightened approach and agreed with the lawyer, and so Bronwyn was given a court order to reside in the supported accommodation. Bronwyn exited through court. The magistrate said to her, "Be good. I don't want to see you back here again!"

Unfortunately, Bronwyn was unable to go straight from court to the accommodation. She had to spend a week with her father until the room at the house became available. During this time, alcohol featured prominently in her life, mainly consumed at a friend's house. At a point when she was highly intoxicated, Bronwyn called a taxi, presumably to return home. When the taxi arrived, Bronwyn threatened the driver with a pair of scissors and demanded money. The driver handed over cash, which Bronwyn threw out of the cab window. The driver called the police, and Bronwyn was apprehended and taken to the police station where she was placed in the cells. She was returned to prison the following day where, at the time of interview, she was on remand awaiting a court appearance. Bronwyn believed she would receive a 16-month sentence. The prison psychologists agreed that this was the likely outcome.

This illustrates the disconnect between service providers and the various arms of the CJS. Had the well-intentioned magistrate been made aware that the room in the supported accommodation intended for Bronwyn was not going to be available for a week, an alternative arrangement intended to keep her safe and crime-free could have been instigated. This would potentially have led to a different outcome in which Bronwyn went to live in the community, supported by trained support workers who could assist her with day-to-day living, accessing employment, managing her money, ensuring her physical and mental health needs were met and facilitating social occasions which did not revolve around alcohol. While there are no absolutes in this scenario—Bronwyn is notably unpredictable—it would at least create the potential to help her have a better, supported and more inclusive life. Bronwyn is unlikely to be

given another opportunity such as this. With an already overloaded system, the priority will inevitably be clients who do not have upwards of 25 custodial episodes by the age of 25.

Appendix 7: Deidre's story

Deidre's story

The following is the story of Deidre and builds on the brief biography presented in Appendix 5. Each of the women's stories are moving. Most reveal a history of events that are confronting. Deidre's story is one such example. However, listening to her convey the way in which her life transpired left an indelible mark. What is unique about Deidre is that she has moved from the darkest place to somewhere that promises a suggestion of light. It is a remarkable journey and, unlike most of the other women interviewed, has the potential for a new life that is in stark contrast to the old one.

Deidre is a 34-year-old Australian woman. She has an assessed IQ of 50. She was eager to attend the interview and spoke non-stop from beginning to end. She presented as a little nervous, but extremely kind and considerate. She is enormously proud of how far she has come in the three and a half years she has been incarcerated, especially the fact that she was granted parole on her first application. Given the heinous nature of her crime (see Appendix 5) this is unusual, but the parole board acknowledged the coercion exercised in the commission of the crimes and the number of rehabilitative programs Deidre had completed in prison.

Deidre started the interview by saying that when she first came to prison she was unable to read, write or spell, but she can now do these things. She constantly used phrases such as "you wouldn't believe how far I've come since I've been here" and "you wouldn't even recognise me from three years ago". She also said that when she went before the parole board, they told her they had never seen anyone who had done as many programs and put so much effort into trying to change. Deidre said she took all her certificates with her to the parole hearing and the board were very impressed.

Deidre lived with her mother in a rented house. From ages 6–13 she attended a special school. Deidre hated her mother, who died in 2010. Her mother was an abusive alcoholic, schizophrenic, bipolar, suffered from depression and, on several occasions, was administered electric shock treatment. She also had an ID. During this time, Deidre was rarely fed as there was very little food in the house. She would steal money from her mother's purse and hide it under the carpet in her bedroom. She would then take it to school to buy food. Deidre relied on the school to give her breakfast, and so she went hungry through school holidays and during the times she was absent from school.

Deidre was put in respite care or a group home by welfare agencies for two to three weeks at a time every few months. This process began when she was about eight years old and lasted until she was 13. Her mother's drinking and a series of nervous breakdowns were the catalysts for out-of-home care.

Deidre started school aged six and a half. It was a late start due to her inability to walk properly because of poor muscle development in her legs. At 13, she started high school in the Special Education Unit but she "played up" a lot as well as often being sick. At high school, she had a couple of "associates" - they were not really friends. Sometimes they would make fun of her. They would also set her up so that she would end up in trouble. She was constantly taken advantage of. She gave them money to make them be her friend. Deidre did not like school and her low levels of literacy upon entry to prison would indicate that, overall, school was not a happy or successful time in her life.

Deidre has an older sister, Bettina, who is protective of Deidre. Because of her mother's drinking and mental health issues, Bettina was largely responsible for Deidre. However, being eight years older than Deidre, Bettina moved out of home while Deidre was still quite young. Between the ages of 13 and 15 Deidre went to live with her father with whom she was particularly close. Deidre refers to him as her "best friend". He died in 2000, just before the birth of Deidre's first child, Benjamin.

At age 15, she left home and moved in with Murray, 10 years her senior. He promised to "look after me". Deidre was with him for 18 years. She gave birth to Benjamin when she was 16, the first of four children. The relationship with Murray was very violent. The bashings began when she was pregnant with Benjamin. For the first six months, Murray "brainwashed" her and prevented her having any contact with her father, Bettina, Bettina's husband or their children. He told her that Bettina was a bad person and that she (Deidre) should reject her sister. Murray threatened harm to Bettina if Deidre contacted her. He stopped her communicating with anyone at all, even preventing her from going outside.

Murray physically and sexually abused all four children. Deidre was coerced into participating with the threat that Murray would either kill or permanently disfigure the children if she refused. She was addicted to alcohol and drugs. Initially, the drugs were put into her drinks, but then Murray forcibly injected her with heroin. Deidre attempted to go 'cold turkey' in an effort to become drug free for the sake of her children. However, she started drinking heavily instead. Deidre said that it took nearly two years in prison before the cravings stopped. During the early stages of imprisonment, she recalls being very angry while she was 'drying out'.

Deidre attempted to run away from Murray several times. She would go “up the bush” and at one point stayed in someone’s dog kennel. Either Murray would find her, or she would go back because she had no food and was cold. Sometimes she put notes simply saying ‘Help’ inside the older children’s schoolbags, hoping that someone might find them. The only person who found them was Murray, triggering another bashing.

Six years after Deidre moved in with Murray, he brought another woman, Prue, to live in the house. Prue was a willing participant in the sexual abuse of Deidre’s children and also bullied Deidre badly. At mealtimes, Murray and Prue would eat and Deidre would make sure the children received some food. She would then eat leftovers if there were any, otherwise she went hungry. She just got used to not eating. Lucy and Harrison, the two middle children, both have an eating disorder. Lucy and Harrison have been bulimic since the age of five. The psychologist has helped Deidre to eat. She has only eaten in the communal area three times since being in prison and prefers to eat in her room. She is fearful that the other women will throw their food at her. If she receives a meal that looks like it has been tampered with (such as the covering lifted a little from the corners), she will not eat it.

Deidre spent the first six months of her prison sentence in maximum security. When she was transferred from maximum to medium security, she was badly bullied by the other prisoners who were hostile towards her because of the nature of her crimes. Deidre said that up until recently, she has been constantly on edge in prison: “In prison you don’t know what is going to happen. One minute it can be fine, but then there is arguing and bickering and I get scared”. Deidre watches television during the day. She likes true crime shows, especially unsolved murders. She watches anything to do with domestic violence—it is still something that worries her a great deal.

Unfortunately, Prue is incarcerated in the same prison as Deidre. The presence of Prue has made life particularly difficult for Deidre. Prue bullies Deidre, who says that Prue “tries to play mind games with me”. On several occasions, Deidre has removed herself from minimum and gone back to medium to gain respite from Prue. Prue is eligible for parole six months after Deidre, but Deidre said that because Prue violated her bail conditions, it was unlikely that parole would be granted.

Deidre says she now has people who “protect” her. This has come about because she has had to “reveal lots of personal stuff” in order to generate understanding. Now most of the women see Deidre as a victim as well. Deidre says that she generally lives in her room by herself, but the last week prior to release on parole, she has been playing cards and eight-ball with some of

the other women. This is different to the three years she has been in prison where she has had only minimal interaction with the other prisoners. She believes this is because of her many fears, something that the psychologist has been helping her with.

Murray is also in prison in maximum security. However, Deidre is still frightened of him as he has made several attempts to contact her. According to Deidre, he threatened to poison her. Because of this, Deidre refused to eat the prison food as she was frightened that it contained poison. As a result, she lost 24 kgs over an 18-month period. Murray is due for parole after 2023, but is under investigation for more abuse charges so it is likely his term of imprisonment will be increased.

Deidre says that the psychological damage from Murray's "brainwashing" is still present despite all the help she has received. She remains fearful that something bad will happen and that Murray will "come and get me". For the first two years, she was terrified that he was going to come through the window, and so she could not sleep. She also thought that the custodial officers were working for Murray and was particularly scared of the male officers. The psychologist was instrumental in helping her overcome this. Now she is relatively comfortable with the male officers, but it has been a slow process.

The prison psychologists have taught her to do deep breathing and use positive self-talk. Deidre also gently strokes her face. She spoke about how she would gently stroke the faces of her children when they were babies and were crying. She said it soothed them and so she would do it to herself while in prison. Occasionally, when she is feeling frightened or vulnerable, the officers and one or two of the women will walk outside with her.

Deidre said that no-one knew Benjamin had been sexually abused by Prue and Murray. After Deidre had been arrested and granted bail, she went straight back to the police station and provided all the information about the abuse. They obtained a statement from Benjamin. Both Prue and Murray denied the charges, but Benjamin was clear about what had taken place. The police took him very seriously—he was 13 years old at the time. They charged both Prue and Murray. In Deidre's eyes, she obtained justice for Benjamin.

Benjamin had turned 17 by the time the interview was conducted and had returned to school to do Year 9. He lives with his girlfriend at his girlfriend's grandmother's house. Prior to this, Benjamin was in foster care but hated it. He was constantly in trouble for stealing cars and selling stolen goods on eBay. However, since his living arrangements have stabilised, he has remained crime-free. He and his girlfriend attend school together.

Deidre's other children, Lucy, Harrison and Michael, are in foster care and for the past four years have been with the same foster mother (Helen). Deidre loves Helen and says that Helen has paid for a private speech therapist for Michael. The three boys have ADHD and Helen has paid for specialist treatment for Harrison and Michael. Michael (aged seven at the time of the interview) also has a learning disability. Deidre sends Helen Mothers' Day cards that she makes in the prison craft group.

Deidre has no contact with her children, although there is the occasional exchange of letters and she has had one video visit with Lucy, arranged through Prison Fellowship. She receives copies of the children's school reports and photos. Deidre spoke about her video visit with Lucy which occurred 18 months ago. She referred to it as "hard but good". They spoke about Lucy's foster mother Helen. Deidre felt better because she realised that Lucy was happy. Deidre requested another video visit, which was approved by the prison, but it was cancelled on the day because Lucy was scared and did not want to participate. Harrison was also booked for a visit, but after Lucy became anxious, he did as well, so no visit took place.

During the week following Deidre's interview, her parole commenced and she moved to supported accommodation. The prison psychologist (Psychologist 1 MHWP) described Deidre's experience with the Tasmanian Parole Board:

> *Psychologist:* She has a folder, it has all of her certificates in it, and the day she went for parole, she was madly hanging onto it. Because it does take her so much work to get through a lot of these courses, and I think—"yeah, she's done a spectacular job", and it's all been on her own, you know. She never wanted to say, "No, I'm not doing this." They [parole board] said, "We don't think we've seen anyone else who has done anywhere near as much counselling", which they were very impressed by. They were very impressed by her sticking with all of that. They had lots of questions about her associating with [name] and other people that she was involved with before coming into custody, and she's got very clear no-go answers to that, so they were really happy with that side of things too. They also had some communication from us [prison psychologists]. She was quite worried that she wouldn't be able to get her point across. She has trouble sometimes articulating well, and I have gotten quite used to understanding her. Her verbal skills are quite fine, but she just wanted a support person and the parole board said, "Look, don't worry about it. We deal with people with disabilities all the time. If you don't understand something we'll ask again, or we'll ask you in a different way." So she went, and they said that she spoke very well, and that she'd done a great job.
>
> *Researcher:* So did anyone end up going with her?
>
> *Psychologist:* No-one in the end. Her case officer, who is a custodial officer, was there. They generally sit outside the room, but she wanted her in with her, but we sort of made the decision between us that it was a good idea for her to start to stand on her own two feet. She had her parole interview with the parole officer, and I said, "If you

> can do that, and answer all her questions, the parole board will not be a problem at all." I talked her round to going on her own and I think it gave her that—she got a really great sense of pride out of doing that for herself.

Deidre has been assigned a case worker who will help her make the transition. Prior to her release, Deidre had several visits to the accommodation and met with the person in charge as well as some of the other residents. She said there was one girl who she thought she could be friends with. She is both excited and nervous about this new stage in her life. Her sister Bettina has three children who Deidre is anxious to spend time with, and Deidre said that Bettina and her husband will support her when she is released. The thing she is most looking forward to is being able to have a bath. She says she will take her time to get to know the other people in the house.

Deidre wants to surround herself with positive people who are supportive and not involved in drugs, alcohol or crime. She is keen to show people how much she has changed. The only negative aspect for Deidre is the disillusionment she feels when her sister and brother-in-law continually repeat statements such as "Make sure you don't do drugs". She believes this indicates a lack of trust on their part and wants them to give positive words of encouragement instead. She worries constantly that Murray will try to get to her despite reassurance from the prison psychologist and support workers that this will not happen. Deidre continues to feel the trauma of the treatment received at the hands of Murray and Prue and the physical and psychological damage done to her children. The psychologist acknowledged that this will be the most significant barrier to Deidre's recovery and ability to move forward with her life.

Deidre believes that the programs she has completed while incarcerated have been helpful to her. She has done NewPin (parenting program), SHINE (an addictive behaviours program) and 'Change on the Inside' (an anger management program). Deidre has completed a Certificate II in cleaning. She has been a cleaner at the prison and worked her way up to a trusted role where she was responsible for cleaning both staff areas and those accessible to the public. She says that the last week has been boring because she was made "redundant" due to her impending release on parole. She filled in her time doing English and Maths instead. Deidre says her dream job would be either aged care or childcare but admits that this is not possible because of her criminal record and the nature of her crimes.

Her hope for the future is to see her children. She has no desire to have them back as she recognises that her mental health problems mean she would be unable to look after them. She also says that they have "the best carer in the world". Deidre knows the children are worried

that she might want them back again and hopes that they will be reassured that this is not the case.

Deidre said of her early life, “Every time I thought something good was going to happen, it didn’t. Now, I’m just getting used to something good happening”.

Appendix 8: Author's note

As I made my way to the low-security area of TWCC, I heard sounds of laughter. Not just giggling, but fully fledged, raucous laughter. Curious, I made my way to where I thought it was coming from. Sitting on the green grass under the shade of a huge Moreton Bay fig tree was a group of Indigenous women and three Elders. They were doubled over in hilarity. Clearly someone had said or done something that resulted in the greatest amusement. I was struck by the incongruity of the situation. In an environment surrounded by security in all its forms, with prisoners experiencing many levels of despair, sat a group of Aboriginal women in a white man's facility, under white man's rules with white custodial officers in the general vicinity and yet able to see the funny side of something. I have no knowledge as to what the 'something' was but that did not matter. Such laughter in such a setting was not only unexpected, it was unique. I can only imagine that for that short space of time their lives felt just a little better.

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